

PHILADELPHIA, FEBRUARY 10, 1883.

ORIGINAL LECTURES.

CLINICAL LECTURE

ON HERPETIC TONSILLITIS: ITS RELATION TO DIPHTHERIA.

Delivered at the Hospital of the University of Pennsylvania, November 11, 1882,

BY WILLIAM PEPPER, M.D., LL.D.,

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Reported by WILLIAM H. MORRISON, M.D.

GENTLEMEN, — This young woman has been in the hospital for the past ten days, nursing her husband, who is here under treatment, and while suffering from some nervous prostration she has been suddenly seized with an affection which is so common, although not dangerous, that I desire to show her to you. She was a good deal run down when attacked, and has been quite busy, frequently up at night attending to her husband, but she has not been exposed to any septic influences whatever.

She began to complain two days ago of sore throat, difficulty in swallowing, and severe headache. There has been considerable fever; the temperature last night was 102° , to-day at 8.30 A.M. it was 101.4° ; at present, 12.30 P.M., it is 101.8° . There is marked acceleration of pulse. It is now 114 in the minute, but this is partly due to the excitement of being brought before you. Last night there was a little wandering delirium, but this was very slight. There was some vomiting when she was first taken sick, but this soon subsided. There is some engorgement of the glands about the angles of the jaw.

Attacks of this kind are quite common both in children and in grown persons. In meeting a case like this, the first thing that you would do would be to examine the throat, and you will find it presenting various appearances. You may find a mild tonsillitis with some pharyngitis, the tonsils being enlarged, of a dark red color, and projecting toward the median line. Possibly there is some tenacious mucus upon their surface. The pharynx is red and swollen, and is perhaps covered by tenacious mucus; the uvula is enlarged, red, and cedematous. This constitutes a mild

case of tonsillitis with erythematous inflammation of the mucous membrane of the uvula and pharynx. In this simple form there are no points of deposit, nor any white spots upon the tonsil.

Examining the throat in other cases, you find, with perhaps less redness and swelling of the pharynx, that the uvula is enlarged, red, and cedematous, and one or both tonsils are enlarged and reddened. You notice in addition that there are from one to a dozen white spots upon the tonsil, or upon the tonsils, as one or both are affected. These white spots are slightly prominent, rising above the surface of the tonsil. Touching them with a probe, you find that they are not free deposits, that they cannot be stripped off, but that they are beneath the mucous membrane, which is somewhat thickened. You recognize that they are the crypts of the tonsil distended with a clear or cheesy material. There is no true diphtheritic exudation upon the surface of the tonsils. There is a moderate amount of swelling of the glands at the angles of the jaw, but nothing like as great as occurs in a bad case of diphtheria with constitutional infection. The onset of this form of tonsillitis may be most violent. Not rarely, in children, I have seen it ushered in by a convulsion and such acceleration of pulse and heat of skin, which in connection with the sore throat has led me to expect an attack of scarlet fever. In adults this apparently trivial affection may be ushered in by marked chill, vomiting, high fever (a temperature of 104°), rapid pulse (115 per minute), headache, backache, pains in the limbs, intense soreness in the throat, and great difficulty in swallowing.

Not only do we find on the tonsil the white spots which I have mentioned, but I have repeatedly, both in the adult and in the child, but especially in the latter, after these spots had lasted for twenty-four hours, seen them run together and form an irregular white patch, which may be associated with membranous exudation upon the surface of the tonsils, so that in certain individuals this type of tonsillitis may be attended by membranous exudation. It is exceedingly difficult to say how this condition is to be distinguished from diphtheria. I am speaking of the affection which is called by various names, among which are herpetic tonsillitis, herpes of the tonsils, and diphtheritic sore throat (the name by

which it is commonly known). It is also frequently called diphtheria.

In the present case there is no difficulty in making the diagnosis. The tonsils are enlarged, and present (the right one especially) a number of these white spots, which are clearly submucous. This woman has, then, a sharp attack of herpetic tonsillitis.

Let me describe an attack in which the symptoms were somewhat more severe, occurring in a little child whom I have had under observation for the past five years. When two and a half years old, while going through a somewhat severe dentition, she had what I am told was a bad attack of diphtheria. Since she has been under my care she has had perhaps twenty attacks of herpetic tonsillitis. The child lives under the best hygienic conditions which intelligence and money can secure. The attacks come on while the child is apparently well, and are attributable to overheating and taking cold. They come on whether the child is at the sea-shore, in the mountains, or at her city home. They are attended with sudden headache, backache, absolute loss of appetite, rarely vomiting, rapid swelling at the angle of the jaws, enlargement of the tonsils, frequent pulse (140 per minute), high temperature (frequently 103°), and a slight tendency to delirium. Almost immediately a membranous exudation forms on the tonsils, and beneath the mucous membrane are the white spots before described. This membrane can be removed from the tonsils, leaving the mucous membrane beneath not ulcerated. The crypts run together, forming a large white patch which may eventually break down, leaving an ulcerated surface. In other words, this little child has what must be regarded as a local diphtheritic affection. I am strongly opposed to the use of the words "diphtheria" and "diphtheritic" as applied to this form of tonsillitis. These terms are used by many who are ignorant and by many who are designing. There is, however, a great difference between this disease and diphtheria with constitutional infection, and yet it is very difficult to say where the line is to be drawn.

Let me give another illustration. A little child is taken ill with severe nasopharyngeal diphtheria, and dies within twenty-four hours in a state of putrescence. The mother, father, nurse, grandmother,

and myself, who have been with the child, hanging over it, battling with the disease, get herpetic tonsillitis, with profound constitutional depression, from which it takes us some days to rally. I have had the same experience a number of times in my life after exposure to severe diphtheria. I was myself taken sick two days ago with herpetic tonsillitis. I had been obliged to be up late at night, but was feeling perfectly well, and was not conscious of being on the brink of any sickness. On Thursday I was taken with a slight creep, had fever, the tonsils became enlarged, presenting a number of white spots, twenty glands along the neck were swollen, and there was intense depression. Yesterday I was able to do a little work, and to-day the spots have disappeared.

What I wish to impress upon your minds is the difficulty of determining where we are to draw the line between this purely local affection of the throat and true diphtheria; that in certain individuals an attack apparently of this simple catarrhal character, unassociated with any septic influence, will be attended by a true membranous exudation, rendering it impossible by mere observation to distinguish the condition from true diphtheritic sore throat; that there is in such case a tendency to the absorption of some irritating matter, as is shown by the enlargement of the lymphatic glands, by the excessive prostration, and by the marked constitutional disturbance which attends it; and, finally, that in certain individuals the liability to the absorption of infectious matter is apparently so great that from a catarrhal inflammation of high degree, associated with membranous exudation, there is produced secondary poisoning of the system, thus giving rise to true diphtheria.

At this point the necessity for more minute investigation or sounder speculation becomes apparent. As you are aware, Professor H. C. Wood and Dr. Henry F. Formad have, with marvellous patience and extreme difficulty, established the fact that in true diphtheria a specific bacillus exists in the exudation in the throat, and so far as their investigations have gone, they render probable the supposition that constitutional diphtheria is due to the admittance of these bacilli into the blood and tissues, that the constitutional infection is inseparably connected with the saturation of the blood and tissues with the bacilli.

Whether in cases where the disease becomes secondarily a constitutional affection there is in the primary exudation a specific bacillus, or whether there is in the individuals who are disposed to have this secondary poisoning some special anatomical peculiarity of the lymphatic glands enabling them more readily to absorb infectious matters, has not as yet been positively determined. I would direct your careful attention to this question, not only because it is one of great importance, but also because on the way in which it is settled will probably be found to depend the whole germ theory and the relations between grave septic processes to local infection, and particularly to specific bacilli.

My own opinion tends very strongly in the direction of a special vulnerability of the individual as exhibited either in a peculiar vital susceptibility to these infectious matters, or in an actual anatomical peculiarity which allows them to pass into the system, gaining there a foothold and developing some secondary process.

Do not imagine that I mean to say that diphtheria always begins as a local disease, which is followed by secondary poisoning. I am perfectly aware that it also begins as a primarily constitutional disease, the general symptoms appearing before the local lesions, and these latter need not be in the throat, but may involve other parts of the body; but I also believe most confidently, and I hold that recent investigations are demonstrating, that diphtheria may begin as a local affection involving chiefly the tonsils. In some individuals the disease may remain a local affection, a tonsillitis with membranous exudation, while in others the same disease may give rise to true diphtheria, either from the absorption of a specific bacillus, or, as I think more probable, from the presence of a peculiar vulnerability to septic infection.

Let me now consider the treatment of these cases. The patient should be confined to bed, but if you are confident that it is a purely local disease, or know from experience that there is no tendency to septic infection, you may allow a considerable latitude as regards motion. Patients may recover quickly even if not confined to bed. If there is high fever, the food should be light, as broths, arrow-root, milk, and wine-whey. As soon as the fever subsides, the patients should be given strong, nourishing food. They will bear cham-

pagne, claret-and-water, or whiskey, very well indeed. Counter-irritation should be employed, preferably by the application, two or three times a day, of iodine to both sides of the neck. The tonsils and throat should be touched every two hours with a mixture of

Tinctura ferri chloridi,

Aqua, equal parts,

or a saturated solution of chlorate of potassium may be substituted for the water. In the case of children there should be two parts of water or solution of potassium chlorate to one of the tincture of the chloride of iron. In the intervals the patient should frequently gargle the throat with a saturated solution of the chlorate of potassium.

Quinia, in doses of four grains every four hours, should be administered. Aconite should be given at the same time. The best plan is to give one drop in water every two hours until six drops are taken, and then suspend the remedy for twelve hours. I do not order aconite, even in one-drop doses, to be continued indefinitely. I always like to see patients who are taking aconite, at intervals of six or twelve hours. As soon as the fever is reduced, tincture of iron and chlorate of potassium may be combined with the quinia. Guaiacum has some specific virtue in tonsillitis, and should be given in the form of lozenges.

Under this plan of treatment a cure may confidently be promised in four or five days. The patient will be left weak, but will rapidly convalesce. After one attack he is exceedingly liable to similar attacks in the future. They are most common after exposure to some septic influence, but may occur from simple exposure to cold and damp.

This disease, from its serving to explain and illustrate other throat-troubles, from its frequency, from the violence of its constitutional symptoms, from the promptitude with which it yields to treatment, and from the amount of humbug which it gives rise to, should be thoroughly understood and promptly treated.

In the treatment of this affection I have recommended pretty strong doses and a good many of them, and I have spoken of the rapidity with which it yields to treatment; but I desire you to understand that cases will get well without active treatment, although it may take longer. But suppose that the disease occurs in one strongly dis-

posed to the absorption of septic matter, or suppose the local disease should be followed by diphtheria; in such a case this active treatment would have been of the greatest benefit. I have never been able to reconcile myself to the propriety of trusting these cases to simple remedies: I always attack them vigorously and get them under control as quickly as possible.

ORIGINAL COMMUNICATIONS.

THE TREATMENT OF TYPHOID FEVER WITH IODO-PHENOL.

BY HUGO ENGEL, A.M., M.D.,

Fellow of the American Academy of Medicine, etc.

THE German physicians were the first to recommend, as an abortive treatment in typhoid fever, one or more large doses of calomel to be given in the earliest stages of this disease. There is no doubt that whenever, under such circumstances, large doses of the mild chloride of mercury (from eight to fifteen grains) are administered, a small part of it becomes changed in the alimentary canal into the bichloride. How are we otherwise to explain the well-known fact that occasionally such a dose of this mild mercurial preparation, even if a purgative is sent after it, is followed by grave salivation? The researches of Klebs, Koch, and others have undoubtedly proved that in enteric fever bacilli are present, and mainly at the seat of the morbid lesion, whether they be the real pathogenetic cause of the zymotic malady or not. Carefully-performed experiments have also established the bacillicidal properties of the bichloride of mercury; no cultures of germs are possible after the natural or artificial germs have been exposed to the action of a one-half per cent. solution of this drug. According to Klebs,* in the beginning of abdominal typhus the bacilli typhosi, following the law of gravity, and influenced by the temporary arrest of peristaltic motion at this locality, mainly accumulate, when they have been introduced into the human organism by food, in the lowest segment of the small intestines, near the ileo-cæcal valve, from where they migrate to other parts of the body. The mercurial preparation would come in such a case in direct contact with the germs, and, by

either washing them away or making the greatest part of them innocuous, the disease naturally will run a milder and therefore a shorter course. That such is the case when typhoid fever attacks mainly the alimentary canal, and when the remedy is given early in the disease, cannot be denied.†

Iodine exerts a similar influence; and that here theory and practice harmonize, is seen from the fact that a case of typhoid fever, when treated with iodine, will run a far milder course, as regards the abdominal symptoms, than if not treated with this remedy.‡ That, in case this theory is correct, carbolic acid should induce a similar effect, can be guessed from its antiseptic properties. With the latter drug Rothe§ has especially experimented, and the success he achieved with this remedy, and the long-established and well-earned reputation iodine has gained for itself in the treatment of typhoid fever, caused Dr. Klamann of Luckenwalde|| to unite the two remedies, and under the name of iodo-phenol they are now made use of all over the continent of Europe, and are considered to form the most effective treatment in enteric fever so far known. As this disease may be said to be endemic in most parts of our country, I thought it best to make the readers of the *Medical Times* acquainted with this treatment, and, to give them as much information as possible regarding the same, I will in this article follow closely Dr. Klamann concerning his method and his experience with it. He mentions as the invariable effect of this remedy the following facts:

The discharges from the bowels always diminish in number and become more consistent, and in some cases, if the remedy is given very early in the disease, the latter will run its course totally without diarrhoea: constipation even will ensue, and this he says took place also when other cases, not treated with iodo-phenol, showed the type of the disease to be one associated with much diarrhoea.

The color of the passages soon assumes a more normal hue. The tongue loses its dryness and becomes moister. The thirst decidedly decreases. The appetite is re-

† Ziemssen's Cyclop., Bd. II. Nothnagel, Berl. Klin. Wochenschrift, 1879, Nos. 41 and 42.

‡ Jürgenson, Deutsch. Mediz. Zeit., 1882, 49.

§ Rothe, Deutsche Med. Wochenschr., 1880, 11 and 12. Conf. Memorabil., January, 1882.

|| Allg. Med. Centr. Zeit. Klamann: Die Behandlung des Darm-typhus mit Iodphenol, October 17, 1882, No. 81.

* Arch. für Experim. Physiol. und Pharmak., 1882, Heft III., IV.

established; a longing for food, especially solid food (though it would not be wise to permit its being satisfied), is apparent much earlier in the disease, sometimes at the end of the first week,—a most remarkable phenomenon, as there is usually the strongest disgust for food of whatever nature.

In milder cases all febrile symptoms cease within a few days after the administration of the medicine has begun. In grave fatally-ending cases, a favorable influence of the remedy on the general symptoms and the general feeling of the patient cannot be denied, but it evidently does not prevent lung or heart complications, nor does it cause any alteration in them.*

Intestinal hemorrhage seems to be totally prevented by the medicine. Klamann noticed it only once among one hundred and ninety-six cases treated with iodo-phenol, and this happened during convalescence in a decrepit woman suffering from a tumor of the liver.

In grave cases which have progressed to a late stage, the remedy does not exert such a beneficial influence as when administered in the beginning of the disease.

Sometimes patients will have a disgust for the medicine, and cannot be induced to take it. In such a case it should be administered in some more palatable form, perhaps in gelatin capsules, which are easily dissolved in the stomach.

Occasionally the drug causes an increase in perspiration, but this is never the case to a great degree.

Being afraid of causing intoxication by larger doses of carbolic acid, Klamann administered the remedy in small and repeated doses only. The formula he employed was as follows:

R Tinct. iodini, 0.5;
Acid. carbolic., gr. x;
Glycerin.,
Alcohol., aa, ʒx.

M.—S.

Of this solution from five to ten drops were given in coffee or tea every hour to two hours.

As tannic acid has proved to be a very valuable remedy in the diarrhoea of typhoid fever, Klamann frequently added to this solution the tinctura ratanhæ. The latter exerts also a beneficial influence on the taste of the medicine.

* This agrees with what I said in the beginning, and shows the local action of the remedy.

Notwithstanding the fact that Klamann is rather sceptical concerning the so-called antiseptic treatment of typhoid fever, he was forced to the conclusion that iodo-phenol possesses a curative effect upon the morbid lesions caused by the poison of enteric fever; but this salutary influence seems to be limited to the intestinal affection, with which it comes into direct contact. A diminution in the swelling of the follicles, however, a healing of the ulcerations, and a decrease or cessation in the hyperæmia of the intestinal mucous membrane, will *eo ipso* have an antipyretic effect. Considering the great vitality of microzymes, I cannot believe that iodo-phenol has a really antizymotic, bacillicidal, disinfecting influence on the general system, at least in the doses given; its action is purely a local one, and therefore the greater the earlier in the disease it is administered.

Small and repeated doses are by all means to be preferred to larger ones more rarely given. That even the small doses exert an antipyretic effect Klamann noticed in all mild and also in graver cases which had progressed to some extent before the medicine could be administered. Especially in regard to carbolic acid, Klamann believes it to be well to follow the advice of the cautious physician: "Tantum me noceas, dum vis prodesse memento."

The following two cases will best instruct our readers regarding the administration and the action of the remedy. Both are reported by Klamann.†

Case I.—Ernestine Kühn, æt. 19, was forced to seek her bed August 24, 1881, having complained for about a week of pains in the extremities, the back, and the sides, and of being very thirsty. August 25, Klamann examined the patient, and found all the symptoms and signs of typhoid fever. In the forenoon the temperature in the armpit was 39.9° C., pulse 105, soft and compressible. There were present, besides, a dry tongue, meteorism, swelling of the spleen, roseolar eruption, diarrhoea, febrile urine, no albumen. Directed, three to four times daily, five to ten drops of the solution of iodo-phenol internally, and local application to the abdomen of flannel dipped in tepid water. August 29, four days later, constipation, pulse 88, temperature 38.8°. The margin of the tongue had become moist, and patient felt a desire for food. September 5, the tongue had a normal appearance, appetite was good, and in the

† Loc. cit., p. 1030.

evening apyrexia was noticed. Within twelve days, therefore, all fever had ceased, notwithstanding that the treatment consisted only of iodo-phenol and tepid local applications. The case was not a spontaneous cure, as the patient expressed herself much better soon after commencement of the treatment, and, as she said herself, each dose of the remedy made her feel better in general.

In the same house another woman became sick with typhoid symptoms. Iodo-phenol was immediately administered, and within a few days the symptoms all ceased.

Case II.—Mrs. Kralisch, æt. 43, insisted that she had been suffering since February, 1880, principally with profuse perspiration. April 9 of the same year, she came under charge of Klamann, after she had been in a febrile condition for two weeks. On examination, the following was found: chronic bronchial catarrh, moderate enlargement of the spleen, mild meteorism, increased thirst, and diarrhoea. A few rose-colored spots were noticed on the abdomen, and, as the discharges had all the characteristic properties of those of abdominal typhus, the diagnosis of typhoid fever was made, and treatment accordingly instituted.

The patient was told to take five drops every two hours of the following solution,—acid. carbolic. solut.,* \mathbb{N}° x, tincturæ iodini, 0.2, tincturæ ratanhæ 10.0,—and to confine herself to a fluid diet. April 6, at 5 P.M. the temperature in the armpit was 38.3° , the tongue had become moist and almost clean, perspiration very little, having decreased immediately after treatment commenced. Cough and bronchial catarrh had also decidedly decreased. Pulse 82; respiration undisturbed; constipation. Up to this day five grammes of the remedy had been used. On the 11th the fever had not totally disappeared as yet, but the tongue was perfectly normal and the appetite very good.

April 14, patient had left her bed; no fever, all symptoms disappeared, almost no bronchial catarrh, and, indeed, very good general health. The medicine had been renewed, but the second bottle was not as yet used one-half, so that during the whole course of the illness twenty drops carbol-glycerin, 0.4 tinctura iodini, and twenty grammes tinctura ratanhæ had been taken.

As no other remedy, no febrifuge, had been administered, Klamann believes that he had to ascribe the rapid improvement in the health of the patient to the favorable influence of the iodo-phenol. At the same time, he feels himself bound to state that another physician had told the patient that she was suffering from tubercular consumption and had to die: so that psychical

influence might have had something to do with the rapid convalescence.

To this description of the method employed by Klamann in the treatment of typhoid fever we will add a few of his general remarks, which are very true and will be read with interest on this side of the Atlantic. He first speaks highly in favor of small—but by no means homœopathic—doses, frequently repeated, and says that in many cases we gain a far better effect from them than from large doses, which often only do injury to the stomach and frequently do not act, as on account of their size they cannot be absorbed. Further, we are able to make the treatment cheaper to the patient; and this is an object we never should lose sight of in our daily practice. Many physicians go on prescribing bulky bottles, and have no idea how large an apothecary's bill the patient sometimes has to pay. By following Klamann's advice, the sick will appreciate our endeavors in that direction.

In the German Medical Congress of last year, which was held in Wiesbaden, a physician expressed himself that most physicians at present make use of far more medication, febrifuges, and cold water than is good for the sick. Klamann is of the same opinion, and adds that, with the exception of cold water, we do not possess a single antipyretic remedy which is always reliable. And as regards the application of water, he says, with how many difficulties is this connected, and how rarely can it be employed *lege artis*! And as concerns quinine, he admits that in very large doses it will decrease the temperature, but he has yet to see the first case where such doses had really proved beneficial.

While by no means considering the treatment with iodo-phenol as the long-looked-for desideratum, he thinks that, if administered according to the manner described, this is the best remedy we possess at present for typhoid fever, as we can achieve more by its agency, and this with greater certainty, in a smaller quantity, and at much less cost, than with any other drug.

507 FRANKLIN STREET.

It is stated that the French nation only began generally to use tobacco in 1830, and now spends nearly ninety millions of dollars a year on the Virginia plant.

* Acid. carbolic., glycerin, partes æquales.

MINOR DYSPEPSIA.

Read before the Philadelphia County Medical Society,
January 10, 1883.

BY WILLIAM R. D. BLACKWOOD, M.D.,

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of the Society.

INDIGESTION is the bane of America, especially in the West and South, where gastronomy is a duty more than a pleasure, and where the main object of sitting at table appears to be divided between getting a full share of whatever is on hand (or more, if possible) and cultivating the art of deglutition at a rate so rapid as to make it almost a science. The peculiar attachment, amounting almost to reverence, for pork, corn, and salæratus, characteristic of the geographical region referred to has also a considerable bearing on the widespread dyspepsia of the citizens thereof; and, whilst the people of the Northern and Eastern States are not so gravely careless in these respects as their neighbors, they, too, frequently prostitute comfort and rational refreshment to suit the exigencies of business on every day except Sunday, and even then with very many the habit of hurried eating throughout the week begets a desire to leave the table as soon as may be, with the possible additional incentive that they may not be late at church.

The treatment of dyspepsia is frequently rendered difficult from the fact that the effort is usually directed to urge the action of the stomach alone, or that and the nearer large intestine, the prior mechanical treatment of the food, in both culinary preparation and mastication, being too often overlooked. A good cook is a *rara avis in terra*, and all of them—good, bad, or indifferent—are a terror in the kitchen to a mistress who proposes to invade their dominion, be she otherwise never so good-natured. The consequence is that they are, as a rule, left to their own devices, and, between rawness of the viands generally, frying instead of broiling, soda to make vegetables tender, an old penny in the pot to heighten the color of the greens, with other dodges known only to the initiated and kept religiously secret from their vulgar employers, we take things as we get them and are thankful. The family physician is rarely inquisitive enough to go into this phase of the matter, partly because he may be ignorant of the necessity for such investigation, and possibly

for the reason that he knows how it is himself at home, and he accordingly despairs of originating a needed revolution.

If the defective preparation of the food as the first step be admitted as a cause of dyspepsia (and there is no doubt of this), as a second the hurried bolting of the meal so noticeable at table, before it is sufficiently masticated and insalivated, is also a factor of vital importance; for, although the stomach is an organ of wonderful patience, it breaks down after a time, for it is not anatomically or physiologically competent to do the work of the machinery preceding and succeeding it, and it would be just as sensible to hold the bolter in a mill responsible for refusing to break up half-ground grain into fine flour as to expect the gastric organ to liquefy the masses of gristle or pulverize the cubes of meat (not always the tenderest) and blocks of dry bread which pop into its cardiac extremity without the slightest warning. After much tribulation under such circumstances with the conglomerate mass to no purpose, it is obliged to reject it, either by emesis, or passing it on, bereft of thorough preparation, to its successor in action, the large intestine, whereupon the scene is re-enacted, the semi-digested mass irritating the bowel as it goes, and carrying before it as a sweeper some of the well-dissolved and matured chyle, and much of the epithelium of the tube it traverses. It is fortunate that the rectum is largely obtuse, for it is with dyspeptics obliged to accommodate not only the legitimate debris of the ingesta, but also particles of a solidity never designed to reach it. It is, of course, well known that digestion really begins in the mouth; and, this being so, it behooves us to see, in investigating a case, whether the teeth and salivary glands are competent to do their work. It is not only necessary that the teeth should be sound and strong, that they may cut, tear, and grind the material during insalivation, but I am convinced that carious dentine exerts a bad effect on food, and that a septic taint is frequently thus given to the bolus before swallowing, for "a little leaven leaveneth the whole lump," and a little tainted saliva in a delicate subject may, and no doubt does, impair not only thorough amylaceous digestion, but also leave its bad impress on each succeeding step throughout the intestinal tract. Highly-spiced food and immoderate draughts of water during eating

also interfere with the due performance of the work which should be accomplished in the mouth, by diluting the saliva, reducing its alkalinity, and lessening the viscosity of the buccal mucus intended to coat the bolus so that deglutition shall be easily accomplished. A third step in imperfect digestion arises in the stomach itself, through impaired function. True, gastric indigestion is usually associated with depressed general health,—the so-called atonic dyspepsia, the main difficulty being simple loss of power through defective innervation; but serious derangement of the organ may result from chronic congestion resultant from the habitual use of alcohol in persons whose general condition is as yet apparently perfect.

In all large cities this is a common variety, especially with men about the prime of life who are additionally slaves to tobacco. The hyperæmia of the mucous membrane prevents free action of the gastric follicles; hence the gastric juice is less abundantly poured out, and, as this fluid is largely laden with pepsin, whose action is to complete the formation of chyme, the result of perfect digestion of the albuminoids, and as seventy ounces or thereabout of the fluid in question is required daily, any material hinderance in this direction must be a matter of moment. Failure of the food to undergo thorough solution in the stomach begets a tendency to flatulence in many people, and, as this malady is most frequently met with in persons addicted to the pleasures of the table, it becomes at times extremely unpleasant, for during a long session at the festive board borborygmus generally announces itself unsought and precipitately, being apt to originate through mental emotion, as, for instance, at the conclusion of a speech, a song, or other music, when sympathy for the performer (especially if he be the victim himself) causes "the bowels to yearn," as the old phrase goes, a proceeding more physiological than elegant, particularly if good peristaltic action carries the wind in a normally downward course, when nothing short of the most violent effort will restrain it within bounds.

Generally speaking, stomach-digestion is chiefly histogenetic or nitrogenized, and it is, therefore, important that it should be well performed, otherwise nutrition suffers. It is because of this failure that confirmed dyspeptics are so lank and limber-

looking. People who will drink wine habitually at dinner should therefore dilute it thoroughly, preferably with a mildly alkaline mineral water, as Vichy, seltzer, or one of those so readily found in our home springs; and alcohol thus diluted is less apt to disagree if taken as near the close of the meal as possible, because the stomach has had a short time at least to work without the gastric juice losing its pepsin through precipitation by undiluted alcohol, and so much chyme as may have passed the stomach to take its place with the carbo-hydrates about to undergo calorific or intestinal digestion is, of course, available as nutritive material.

The fourth point involved in dyspepsia is from defective duodenal digestion; and here several agencies may be at fault. As with the stomach, the intestinal glands may be inactive, and the pancreas may be sluggish; but by far the most common defect is a perverted state of the hepatic function, for although the bile secreted by the liver does not in itself exert much, if any, effect in the direct digestion of either nitrogenized or amylaceous food, a congested state of the organ obstructs the active flow necessary during digestion in the entire gastro-intestinal circulation. Here, again, alcohol interferes indirectly with intestinal digestion, as it did directly with the gastric function, by neutralizing the action of pancreatine upon the contained mass, and thus not only interfering with saponification of the fat and oils, but preventing the amylaceous bodies which had escaped buccal or salivary action from an opportunity for solution by the once again alkaline action to which they are here subjected.

Beyond the duodenum we are not concerned in our consideration of the minor dyspeptic ailments. Of course the chyle as it flows onward is subjected to digestive action after leaving the superior intestinal tract, but it is chiefly through what has been done already, and from continued action of the gastric and particularly the pancreatic fluids therein contained. Absorption is now the main point, and this is not much interfered with even in confirmed dyspeptics below the large intestine.

Time will admit but little reference to treatment, and in all forms of indigestion prevention is better than cure. Besides attention to proper preparation of food, regularity in eating, moderation in amount,

adaptation of diet to personal peculiarities, and avoidance of immoderate indulgence in stimulants, the dinner especially should be deferred till after the close of the day's business, rather than eaten hurriedly, a simple glass of milk with a biscuit being taken at mid-day instead of the usual leather pie and beer or whiskey, and the cheerful presence of the family circle in the evening around the table will go far towards making enjoyable to many a hard workman what is too often otherwise a mere mechanical business at noon.

The indiscriminate use of bitters, cordials, and the like is indefensible on rational grounds; and the great majority of the artificially-prepared pepsins and pancreatines are utterly useless, as in the condition usually found they are saccharated (or adulterated with milk-sugar) to an extent unknown by the physician, and, despite the laudatory effusions so readily obtained by any and every manufacturer from regular, irregular, and defective doctors, professors, secretaries, ministers, and members of Congress, in the vast majority of dyspepsias these compounds are utterly inert. If you want pepsin, give it, and omit the lactose; and the same with pancreatine. Bismuth, also, has been blindly handled, especially in combination with pepsin, whose action it neutralizes. Whilst of undoubted service at first in acidity of the stomach, it eventually lines more or less the intestinal tract with an impervious coating, seriously hindering the production of the mucous and follicular secretions. The nitro-muriatic and phosphoric acids are much better, and, if urgent need prevails, the administration of a soda or potassa salt for a short time will do much more service than either the subnitrate or the subcarbonate of bismuth. In all forms of dyspepsia strychnia or nux vomica is extremely valuable; and where acidity or constipation is present, very small doses of belladonna, with at times cascara sagrada, will remove the difficulty.

Regular exercise, especially equestrianism, is very efficient in atonic conditions, and, where this cannot be had, walking, together with abdominal massage, is good. General faradization of the abdomen is an admirable method of toning up the peristaltic action, particularly in constipated patients; whilst galvanism is unusually efficient in hepatic torpor, and static electricity in my hands has acted promptly, thor-

oughly, and permanently in relieving the dyspepsia so common in nervous, hysterical school-girls. Where liver-congestion exists to a decided degree, the employment of mercurials, such as calomel, blue mass, or hydrarg. cum creta, is better avoided, because of their blood-defibrinizing quality, and recourse should be had to one or more of the efficient agents long used by the eclectic fraternity and lately investigated in a series of exhaustive experiments by Rutherford and others. Of these, podophyllin, irisin, and euonymin are the most valuable; but I am in the habit of combining them with very felicitous results, and at the risk of being criticised I annex a favorite formula used for many years, and it is, I may say, the only one approaching the so-called "shot-gun" prescription which I ever use, my habit otherwise being to order simply one ingredient, or at the most, and that rarely, three, in any one recipe. It is as follows, and I prefer Keith's *freshly-prepared* manufacture:

℞ Cinchonidix sulphatis,
Euonymin.,
Irisin.,
Leptandrin.,
Juglandin., aa, ʒss;
Podophyllin.,
Ext. belladonnæ,
Ext. nucis vomicæ,
Ext. hyoscyami, aa, gr. x.

M. In pil. no. 60 div.

Sig. One or two at bedtime.

Many a stubborn case of dyspepsia that had run the gauntlet unavailingly of all sorts of peptonoids has given way to this, and it is an admirable chologogue on general principles. In scrofulous subjects with deficient nutrition I have had much benefit from minute doses of mercuric bichloride (the one-hundredth of a grain) in tinct. calumbæ comp., the dose being a drachm of the latter thrice daily. Within a few weeks a most interesting case, treated by several physicians for organic cardiac lesion, has recovered under the remedies just alluded to. The palpitation, the supposed dilatation with compensating hypertrophy according to canonical dicta, has subsided; the patient can lie down, and sleep too when recumbent; he has no night tremor or dread; he can run up-stairs or after a car; he can eat, drink, and be merry now, whereas before he was morose, taciturn; and a family nuisance; in short, he has dropped a minor dyspepsia, and with it a

prognosed incurable heart-trouble. Dyspepsia, like charity, covers a multitude of troubles and sins, and a good deal of the "malaria" so fashionable with the fraternity and with the laity also is one or another form of indigestion.

I must apologize for the incompleteness of this paper, which was written hurriedly to fill a sudden gap in our promised series, but I hope it will by its very meagreness draw out, now or in the future, something of value from some of our friends present who are much more capable than myself of doing the subject justice.

246 NORTH TWENTIETH STREET.

SOME CASES OF PNEUMONIA IN THE ADULT SIMULATING MENINGITIS.

Read before the Philadelphia County Medical Society, January 10, 1883.

BY J. T. ESKRIDGE, M.D.,

Physician to the St. Mary's and Howard Hospitals.

THE chief symptoms in the following cases of pneumonia pointed to the brain, instead of the lungs, as being the main organ diseased.

I desire to express my indebtedness to my friend Dr. O'Hara for permission to use in this paper the notes taken on a case of pneumonia under his care, occurring during his recent term of service at the St. Mary's Hospital.

Case I.—James F., æt. 37 years, Irishman, laborer; enjoyed good health until about the 1st of July, 1882, when a diarrhœa, from which he suffered until his death, began. The latter part of July he was accidentally struck over the right eye with a large piece of coal. The bone was laid bare, but apparently not broken. The wound soon healed kindly, and he was not confined to his room more than three or four days. Feeling weak from the continued diarrhœa, he stopped work August 6, and the next day went to Atlantic City, where he stayed about forty-eight hours. August 14 he became very delirious, and suffered from high fever. Two days later (August 16) he was brought to the St. Mary's Hospital at 9 A.M. Temperature 104°; pulse 130; respirations 40. He was unconscious. The delirium at that time was violent, and two attendants were required to hold him in bed.

At 12 M., being engaged in another ward of the hospital, I was asked by Dr. Everett, the resident physician, to see the patient, as Dr. O'Hara, the attending physician then on duty, had not arrived. I found the temperature 104.8°; pulse 140; respirations 48, blowing,

and semi-stertorous. The pupils were widely dilated, the eyes staring and rolling from side to side. A cicatrix about one and a half inches long, stained black by coal-dust, in which he was working when he received the wound, was noticed over the right orbit, but the external table of the bone did not seem to be depressed. The arms were rigid and at times affected by tetanic convulsive movements. Occasionally he would become markedly opisthotonic. All the muscles of his body seemed to be in a constant tremor. He would lie a few minutes without making any effort to rise, but in an instant he would make a quick and violent plunge, several times nearly succeeding in freeing himself from those who struggled to hold him in bed. So violent and explosive were his movements that I did not care to risk my head near enough to him to enable me to examine his heart or lungs. He was insensible, and did not wince when his flesh was deeply pierced by a needle. When spoken to, he endeavored to speak, but his answers were unintelligible. No muscles were paralyzed. About that time Dr. O'Hara arrived. We were of the opinion that his trouble was some brain-lesion, probably meningitis. As he appeared to be sinking and death imminent, we decided to stimulate by means of brandy, ammonia, digitalis, and belladonna, administered, if necessary, hypodermically.

He died about 1.30 P.M., one hour after we left him.

On account of the recent injury above the eye, and because death resulted so soon after his admission, while brain-symptoms were so prominent, and before a satisfactory diagnosis was made, the case was reported to the coroner. He, however, courteously permitted the post-mortem examination to be made by the physicians connected with the hospital.

Sectio cadaveris was made twenty hours after death by Dr. Everett and myself, in presence of Drs. O'Hara and Moyland. Body considerably emaciated.

Brain.—The membranes were congested, the blood-vessels being highly engorged with dark venous blood. The dura mater was abnormally adherent to the skull-cap, but no decided evidences of recent inflammation were seen. One or two ounces of serous fluid at the base of the brain were found. The ganglia and brain-substance were nearly normal.

Thorax.—The heart and pericardium showed no signs of disease, except that the right ventricle contained a good-sized ante-mortem clot. A few pleuritic adhesions, recent and old, existed at the base of each lung. The entire right lung was consolidated. Sections discovered several small points of supuration in the lung. The left lung was nearly normal.

Abdominal Cavity.—The peritoneum was hyperæmic, but no lymph or adhesions were

found. The bowels contained considerable fluid fecal matter. The mucous membrane of the small and large intestines, more especially of the ileum and colon, was congested. Peyer's patches and the solitary glands were not prominently involved. The mesenteric glands were a little enlarged, but not much injected. The liver, spleen, and kidneys seemed to be passively congested.

Case II.—During October, 1882, I was called to visit Peter R., 45 years old. He was a laborer, and addicted to drink. I could obtain no further history than that a few days before he had been attacked by a severe fever and soon became delirious. A physician who had recommended his removal to an asylum had seen him a number of times.

I first saw the patient at 11 A.M. His hands and feet were cool; pulse weak, rapid, and almost imperceptible; respirations short, and 60 per minute; temperature 103°. No paralysis or spasmodic movements of any of his muscles observed. His pupils were nearly normal. When food and drink were offered him, he clinched his teeth and refused to take either. Pinching and pricking his flesh gave him no annoyance. He was tied in bed, his friends stating that it had been almost impossible to prevent him injuring himself and attendants. When I saw him, his delirium was low and muttering most of the time, but at times he became noisy. The heart, free from murmurs, was weak, the first sound being almost imperceptible. The right lung was solid from base to apex; the left over-acting, presented no other evidence of disease. Stimulating enemata were recommended.

6 P.M.—He was in a moribund condition, and died at 8 P.M. No post-mortem examination was obtained.

Remarks.—Pneumonia in children is frequently so marked by brain-symptoms that unless one is on his guard he may entirely overlook the real seat of trouble. Such a deceptive train of symptoms as found in the cases I have reported to-night are rare in the adult, but that such occur is demonstrated, and the fact should make us most careful and searching in our examinations, not only before an opinion is given, but before a line of treatment is entered upon. We cannot be sure of a diagnosis until every organ is investigated.

The symptoms are not difficult to account for when we remember the condition of the brain exhibited at the autopsy in Case I. It is well to bear in mind that both patients were addicted to alcoholic stimulus, and that the first had suffered from an exhaustive diarrhoea during the six weeks prior to being seized by pneumonia. Only

an imperfect history of Case II. could be obtained. He had lost considerable flesh, although he had been sick from the lung-trouble only a few days. It is probable, therefore, that he also had previously suffered from a drain on his system, rendering him more liable to diffuse inflammation of low type, his habit of spirit-drinking making the membranes of the brain irritable and easily violently congested. It is a well-known fact that when the apex of the lung is involved in pneumonic inflammation brain-disturbance is common, but of course rarely so marked as was witnessed in the cases reported in this paper.

The physical signs make an accurate diagnosis easy, and we have in these cases but to remember the danger of mistake to avoid it.

POISONING BY MUSHROOMS.

Read before the Philadelphia County Medical Society, January 10, 1883.

BY HORACE V. EVANS, M.D.

THE mushroom is a fungus so familiar to us all that I must ask pardon for referring, even very briefly, to its botanical associations. It is proposed to call your attention first to the edible and, innocuous variety, and subsequently to the poisonous ones, with a brief report of two cases in which the noxious effect of their consumption was manifested.

The *Agaricus campestris*, the *Tuber cibarium*, and the *Morchella esculenta* are fungi, indigenous to almost every land in which the climate can even for a short period be called temperate.

They grow from the spore, rarely prospering in any but moist soil. Those who cultivate them for market have found that they prosper best in a soil rich in sulphate of calcium.

Analysis reveals the constituents of these edible species to be fungic acid, fungin or cellulose, salts of potash, saccharine matter, and albumen.

The *Agaricus campestris pilei*, though the safest and best of the class for the table, are yet at times objectionable, owing to the irritation and pain following their consumption. When gathered too early or too late, or when growing in a too moist soil, they will often manifest their innate noxious tendency. Hence the propriety of our ever consenting to their employment as food becomes very doubtful. As a rule,

the skilled cultivator can detect the poisonous variety, but the fact that even the innocuous at certain times and under certain circumstances become poisonous (Reese's "Toxicology") shows that even the expert cannot at all times guarantee immunity to the consumer. The absence of the pink or purple color in the gills of the fungi should at once condemn them as certainly poisonous.

The conspicuously noxious species are the *Amanita muscari* and the *Amanita venanta*. They have a narcotic fetid odor, an acrid, bitter, and acid taste, are corky to the feel, and exude a milky, acrid, and styptic juice. When bruised they assume a bluish tint. The cap has a conical or flattened shape; their color varies from yellow, brown, green, and red, to yellow or orange.

In the usual process of cooking (namely, incomplete boiling, and the utilizing of the fluid in which they are cooked as a constituent of the dressing or dip), the poison becomes more active than when they are eaten in the uncooked state.

The safest manner of preparing the mushrooms for the table is to soak them for several hours in strong salt water, then rinse them in fresh water and boil them rapidly for a short time; again remove them from the water, and cook them in milk and whatever *etceteras* the taste may dictate.

My experience in poisoning by the noxious varieties is confined to two cases. In both instances the subjects were young ladies. They had eaten them in the uncooked condition and on empty stomachs.

After four hours the individuals became dizzy, with the sensation of constriction in the head and abdomen, vertigo, with a staggering gait, dryness of the fauces, a rapid and full pulse, with elevated temperature. These symptoms were within two hours succeeded by a wild and apprehensive delirium.

Active emetics, followed by cathartics (in one instance four ounces of castor oil were administered at a dose), very soon removed the offending cause. The internal use of ether at first palliated, and within three hours subdued, all the threatening symptoms.

These were typical cases of the first stage of poisoning by toadstools. Had not the condition been recognized and the treatment promptly resorted to, the

subsequent and more serious train of symptoms usual in these cases would in all probability have followed.

The treatment consisted of mustard infusion and sulphate of zinc as emetics, followed by prompt yet non-irritating cathartics. Nothing seemed to act so quickly in subduing the excitement as ether.

CASES OF ACONITE-POISONING.

BY P. HOOPER, A.M., M.D.

I WAS summoned, on the evening of December 23, 1882, at 10.45 P.M., to "come immediately to see a woman who was nearly dead in a drug-store." I went at once, and found I had two patients instead of one to treat,—the woman, Mrs. D., whom I was called to see, and the druggist. My lady patient I found perfectly conscious. She gave me a history of the case, as follows:

"Doctor, am I going to die? Taste what I have taken,—there it is on the table,—and tell me. I never had such feelings in my life: my flesh is tingling from head to foot. This evening I bought at this store what I have been accustomed to take for biliousness and indigestion,—a package of dandelion root. I steeped the root in a pint of warm water, and drank about two-thirds of a gobletful. In about three minutes I felt a terrible pricking and tingling feeling in my tongue and lips, soon afterwards in my arms, and then from head to foot. I asked my husband to taste it; he did so, but, becoming alarmed, he vomited, which he can do very readily, very soon after drinking it. My husband's brother also drank a little of it. My husband and I started at once for the store with the remainder of the decoction. The druggist assured me that it was dandelion root, and to satisfy me drank some of it. He drank the greater part of the decoction remaining in the glass jar which I brought with me. Very soon after he had taken the second drink, he gave me an emetic and took one himself. He repeated the dose of the emetic for us both, and said, 'You must have a doctor called immediately.' The emetic has not acted in my case, for it is difficult for me to vomit."

While she was telling me this, I had taken a very little of the decoction (about a quarter of a teaspoonful), and almost as

soon as it had touched my lips my tongue began to tingle, and I had no difficulty in making a diagnosis of *aconite-poisoning*. I ordered a heaping tablespoonful of mustard in a glass of water. This Mrs. D. drank. After she had swallowed the last of it, and still did not vomit, I told her to run her fingers as far down her throat as possible. This brought on violent retching, but very little of the stomach's contents were vomited. I felt for her pulse, but it was imperceptible. I asked her to stand on her feet; she said she felt as if she were paralyzed and could not do it. I helped her to her feet, but she could not stand, for every muscle and fibre of her system seemed to be vibrating. I urged her to keep her fingers down her throat, and soon I was rewarded for my exertions by her vomiting quite freely. I looked at the eyes, and found the pupils dilated. Very soon purging set in, and she had one free movement of the bowels. After this I placed her on the sofa, and told her to keep perfectly quiet. I again felt for the radial pulsations, and found the pulse still imperceptible. My patient was constantly quivering from head to foot. Knowing that any other kind of treatment than the heroic is folly in desperate cases, I called for tincture of digitalis, intending to use it as the physiological antidote. Not having my hypodermic syringe with me, I gave a drachm dose by the mouth. I told Mrs. D. that she must be put to bed and kept absolutely quiet; that she must lean on my arm, and I would support her to a bedroom. For several moments the fear of death seemed to be driving her almost wild. The dread of death, which, she said, was the only thing in the world she feared, seemed to come sweeping over her like the surging waves of the sea.

She leaned heavily upon my arm while I supported her to a bed. I had her placed on it, keeping her head lower than her feet. She complained of some nausea, but, by keeping her in the position I have described, the feeling soon passed away. I now continued the administration of tincture of digitalis, giving her a drachm dose one half-hour, and a half-drachm dose the next half-hour. After she had vomited a great deal, and before I had given the second dose of digitalis, there was considerable muscular relaxation, and I felt her pulse, but it was very feeble, and ranging from thirty to forty beats per min-

ute, sometimes beating slower and sometimes faster, and at times it was intermittent. Within half an hour after giving the digitalis I felt an improvement in the pulse, yet it was two hours and a half before the physiological antidote began to act as I wished it to. After five hours I considered the greater part of the danger past. Between 2.30 A.M. and 3 A.M. she complained of her arms and legs feeling numb. I ordered them to be rubbed briskly, and assisted myself. At 4 A.M. her pulse was full and strong, yet she was still nervous. I assured her that she would recover. She now, for the first time, seemed to place entire confidence in me, and to implicitly believe my word.

About 1 A.M. several of Mrs. D.'s friends came in, and said that her brother-in-law was complaining greatly of the tingling feeling also. I judged that he had taken only a small quantity of the deadly decoction, and, as they did not bring him to me, I had to tell them how to treat him when they reached home. I ordered the same treatment, with the exception of the digitalis, which I did not think needed to be used in his case on account of the small amount he had taken, and I also had some doubts about the propriety of trusting the administration of digitalis to unprofessional hands. In his case I ordered stimulants. I had also given Mrs. D. alcoholic stimulants between the times of the exhibition of digitalis.

During the time I was attending Mrs. D., I stole away from time to time to see my druggist-patient. He had vomited very freely before I came to him: so in his case no emetic was needed. I had him also taken to his bed. The pulse ranged thirty-three, and sometimes thirty-seven and forty, per minute. His respirations were long and labored. His head was kept lower than his feet, and he was kept on his back. Before I supported him to his room I whispered in his ear, "This is aconite-poisoning." He nodded his head, but seemed unable to converse much. I commenced giving him digitalis in the same doses and with the same frequency that Mrs. D. had taken it. In one hour's time the pulse ranged from fifty to sixty beats per minute, but was very feeble and intermittent. At times he complained of a suffocating feeling in his throat, for it was there the poison seemed to act most powerfully. He also felt the tingling feeling from head to foot, and

occasionally a cold chill, almost like the chill of death, would run over his body. He said his tongue felt so swollen and tingling that he did not care for brandy, after I had given him an ounce of it. Back and forward I went to my two patients, spending, however, most of my time with Mrs. D., for she did not wish me to be absent often, or long at a time. I gave the druggist six drachms of the digitalis. Before I had given him his last half-drachm dose his pulse was full and strong, and soon after the last dose was taken he had a digitalis pulse. On examining his eyes I found the pupils dilated.

Mr. D., who was with his wife most of the evening, also felt the tingling through his tongue and lips, but he had not taken enough to need any treatment. I stayed with my patients until 7 A.M. Sunday morning, December 24. I made three visits to Mrs. D. after she was taken to her home. The after-treatment was only demulcent drinks to allay the irritation of the stomach which she complained of. The druggist on Christmas day was able to attend to business. He told me he sold Mrs. D. an ounce of the aconite root, and gave her two ounces of antimonial wine (he first gave one ounce, and then in a few moments gave the second ounce) for an emetic, and that he took the same. He said that he felt the tingling almost as soon as he had taken the decoction of the root, and, if he had not sent for me very soon after Mrs. D. entered, he would not have been able to, for he was very soon prostrated, so quickly did it act in his case. He also said that he felt better very soon after taking the digitalis; that it relieved the oppressed feeling he had. To my mind, the cases prove that digitalis is a valuable physiological antidote in aconite-poisoning.

COFFEE AS AN ANTIDOTE TO ALCOHOLISM.

BY F. P. NOVAES,
Rio de Janeiro.

THE habitual use of coffee (*Coffea Arabica*) has been considered by some writers to be antidotal to alcoholism, and some of them apparently have no doubts on the subject.

One of the gravest questions discussed in the Congress of Geneva was that of al-

coholism, and the means of fighting this terrible scourge, which from day to day makes such frightful progress in Europe, particularly in Switzerland.

His excellency the Baron of Theresopolis, vice-director of the faculty of medicine of Rio de Janeiro, in some remarks made during the discussion of this topic, interested his audience and indicated the means he believed most efficacious to oppose the inroads of alcoholism. He produced statistics showing that the number of drunkards in a country is in inverse ratio to the amount of coffee consumed.

"In Brazil," he said, "where great quantities of coffee are used, and where all the inhabitants take it many times a day, alcoholism is completely unknown. It appears that the immigrants arriving in our country with this terrible passion for alcohol contract little by little the habits of our people, imitating their fondness for drinking coffee, and their aversion for liquors. The children of these immigrants, brought up with coffee from their tender age, never contract the fatal habits of their parents.

"We can, therefore, conclude that the more coffee we take the less desire for alcohol we have. But to obtain such a result it is necessary that the coffee should be of superior quality, such as that from Brazil.

"Send us your emigrants," said the baron; "we have work for them, and they will live under the protection of our government. In turn we will send you our coffee, which is the best remedy for such a trouble as this which you consider incurable."

His excellency may have exaggerated in this estimation of the effects of coffee, but we do not doubt that its use is an excellent antidote to alcoholism. The number of *cafés* in the large cities of Brazil, where hundreds of persons, from the highest down to the lowest classes of people, go in to take a cup of that delicious beverage, which none but Brazilians know how to make properly, is enormous, whilst drinking-saloons or bars are very few, and their patrons fewer still, in consequence of which a public drunkard is a rare person to be seen.

TREATMENT OF ACUTE PNEUMONIA.—Remarkable results are reported by Riebeau-Schwartz from the use of iodide of potassium internally, and ice externally, in acute pneumonia.—*Paris Méd.*, 1882, p. 116.

NOTES OF HOSPITAL PRACTICE.

PENNSYLVANIA HOSPITAL.

CRUSH OF LEGS—AMPUTATION—RE-AMPUTATION.

Communicated by HENRY M. WETHERILL, M.D., formerly Resident Physician in the Department for the Sick.

UPON the twenty-first day of August, 1880, M. S., æt. 6 years, a school-boy, was carried into the surgical ward of the Pennsylvania Hospital, he having been knocked down and run over a few minutes previously by a horse-car at Sixth and Lombard Streets. The wheels had passed over both legs at a point a little above their middle, completely crushing through the soft parts and bones, the parts hanging merely by a few tendons. He had lost much blood, and was bleeding pretty freely from the right stump, when admitted. The shock was profound. Ligatures were applied to the bleeding vessels. Temperature 97° F. External warmth and stimuli brought about fair reaction in about three hours, when he was carefully etherized and his injuries examined.

The skin and muscles of the calves were found to be very much bruised and loosened up above the seat of injury. The tourniquet was then applied over the femoral vessel of the left thigh, and Dr. Elliott Richardson amputated through the left knee-joint, making a long anterior cutaneous flap, including the patella, and leaving in the semilunar cartilages, and making a short musculo-cutaneous posterior flap. The anterior flap at its margin below was somewhat bruised. Five vessels were ligated with silk, and the margins of the wound rather loosely approximated with silver wire. Meanwhile, the boy had almost died upon the table, and brandy and ammonia were given freely, which he fortunately retained, and, his condition presently improving, the writer, by the kind permission and with the assistance of Dr. Richardson, amputated through the right knee-joint by the same method, except that the semilunar cartilages were removed. The margins of both these flaps involved some of the bruised integument. Six vessels were tied with silk, and the edges of the flaps were rather loosely approximated with silver wire, on account of the bruised condition of their margins. Both stumps dressed with adhesive plaster and carbolized lint.

Upon August 25 it is noted that the margins of the anterior flaps are sloughing, especially that of the right stump. Temperature 101°, pulse 104, respiration 26.

In a few days the entire covering of the end of the right stump had sloughed away, leaving a granulating surface bathed in healthy pus and exposing the knots of the ligatures. The left stump is in rather better condition; but the anterior flap has sloughed away in part, exposing a granulating surface which could be about covered by a silver quarter of a dollar. His general condition is bad. He has traumatic delirium. Pulse 120, temperature 103.5°, respiration 30. The note for September 30 says that the boy has weathered through severe surgical fever and delirium and is in good general condition. All ligatures away.

The left stump is slowly closing by granulation, the uncovered portion having been planted with skin-grafts from his own arm. The end of the right stump is an open ulcer, showing not a vestige of flaps. In appearance this ulcer is healthy, but skin-grafts will not grow upon it, although tried repeatedly, both with his own skin and with that of others.

The boy remained in the hospital, improving very much in general condition, preparatory to a re-amputation of the right stump, which was done by Dr. Thomas G. Morton on October 23, at the lower third of the thigh.

He made a very good recovery from this successful re-amputation, and was discharged from the hospital, cured, on January 8, 1881, after a residence there of one hundred and forty days, during which he successfully stood the primary shock following the injury, the shock of double amputation through the knee-joints, followed by extensive sloughing, a high condition of surgical fever, exhausting suppuration, the re-amputation, with more shock, and subsequent drainage. When he left the hospital he weighed about the same as when he was admitted,—which shows a very decided gain, when it is considered how much of his original frame he left there.

I have had this boy under my observation from time to time ever since. He is very stout and active. He does not yet use artificial limbs, and he has wonderfully developed his arms by making them do double duty.

TRANSLATIONS.

PYO-NEPHROSIS AND ITS SURGICAL TREATMENT.—A strong, well-developed woman, 32 years of age, who had a history of some obscure painful affection of the left kidney, but with excellent general health, was seized suddenly with fever, intermittent in type, restlessness, and severe pains in the left lumbar region. After she had suffered thus for a month, ether was administered, and by physical examination a large tumor was detected in this region, extending from the ribs to the crest of the ilium and pubes, and beyond the median line; it was oval in shape, and in the centre fluctuating. The heart was not hypertrophied. The urine was large in quantity, and contained pus and albumen; it was alkaline, and had an offensive odor. Dr. James Israel, who reports the case in the *Berliner Klinische Wochenschrift* (No. 51, 1882), diagnosed pyo-nephrosis, and proposed a permanent fistule through the abdominal wall as a *dernier ressort*,—an operation which was subsequently performed. It was found to be cystic dilatation of the calices of the kidney. Upon opening the peritoneal cavity, a trocar was introduced into the point of greatest fluctuation, and a large quantity of offensive purulent fluid was obtained. A drainage-tube was inserted, and iodoform gauze applied over the wound. Everything progressed remarkably well after the operation; there was no fever, no peritonitis, no pain, and the urine had become clear and acid in reaction, when, on the third day (following a hypodermic injection of morphia), uræmia set in, and the patient perished. At the autopsy, the left kidney was diseased, as stated, and the other kidney was found to be very much contracted, and the site of granular atrophy. The existence of disease of the right kidney had not been suspected during life; the normal quantity of the urine, the absence of cardiac hypertrophy, and the appearance of robust health and unimpaired nourishment of the patient were all against this supposition. The bearing of this upon the question of total extirpation of a diseased kidney in such cases is very obvious. The reporter formulates the practical deductions from this interesting case in the following observations:

1. The diagnosis of unilateral hydro- or pyo-nephrosis having been made, the

possibility of disease in the other kidney—even in the absence of cardiac hypertrophy, and in the presence of the normal excretion of the normal quantity of urine—must always be acknowledged.

2. Therefore the establishment of a fistulous opening into the pelvis of the diseased kidney through the abdominal wall is, as a rule, to be preferred to the operation of extirpation of the affected organ.

3. Where the cystic enlargement of the calices is more extensive than the distention of the pelvis of the kidney, aspiration can still be performed, either with or without preliminary incision into the abdominal wall.

4. The use of narcotics, which reduce the power of the heart, should be restricted as much as practicable in kidney-diseases, which cause considerable disturbance in the circulation.

RAPIDLY-DEVELOPING AND CURABLE GENERAL SPINAL PARALYSIS.—Landouzy and Déjérine report in detail two cases of non-inflammatory rapid general paralysis of spinal origin in the *Revue de Médecine*, (Nos. 11 and 12, 1882), and give a critical review of the literature of the subject, discussing our present knowledge of the pathology, symptomatology, and treatment of these affections. The treatment should be general and local, sustaining the strength by all possible means, and especially by tonics and hydrotherapy, the tendency being towards final recovery. This result may be accelerated by electricity, the nutrition of the muscles being maintained by faradic currents, and the galvanic current of feeble intensity being applied to the vertebral column.

The following conclusions are drawn from a careful study of a number of reported cases:

1. There is a form of myelopathy characterized by—(a) the paralysis and atrophy of all the muscles of the body (those of the face excepted); (b) the integrity of the sensibility of the sphincters; (c) the integrity of the cutaneous nutrition; (d) a rapid evolution (during several months); (e) ultimately, the complete and definite cure of all the paralytic and atrophic troubles.

2. This affection (for which they propose the name of “rapid and curable general spinal paralysis”) is to the acute spinal paralysis of adults what the sub-

acute general anterior spinal paralysis of Duchenne is to progressive muscular atrophy.

3. This disease depends upon some lesion of the cells in the anterior cornua of the cord, the lesion being situated throughout its length.

4. Although the site of the lesion has been demonstrated by pathological anatomy, its nature still remains to be determined.

5. The etiology, as well as the pathogeny, remains very obscure.

6. The recognition of this form of myelopathy presents considerable practical interest, since upon the differentiation depends a favorable prognosis of complete recovery at an early date, where, at the first sight, the intensity and the diffusion of the paralytic troubles, and the atrophy, would lead us to fear a fatally progressive disease.

GUMMOUS OSTEOMYELITIS IN THE LONG BONES.—In a communication to the *Vierteljahresschrift für Dermatologie und Syphilis*, Prof. Chiari, of Prague, reports nine cases, out of twenty-seven examined, in which after death the marrow of the long bones showed unmistakable evidences of syphilitic deposit. He is of the opinion that the central gummata in the medullary structure of the long bones are much more frequently present than has usually been believed; that they are often multiple, and that during life they not rarely remain entirely latent, so that their existence is first discovered post mortem. The histological examination showed these collections to be the products of an inflammatory hyperplasia of the connective tissue, with the same jelly-like appearance as the other gummata of the bony system, such as the periosteal. Many of them showed a tendency to central caseation, but the anatomical appearances were not precisely alike: they varied in appearance, size, numbers, and location. It was noticed with regard to locality that the bones of the lower extremities were most liable to be invaded. In ten cases, there were six in which gummata were found in the femur, in five they were present in the tibia, in four they were seen in the humerus, and once only in the radius.

As regards local symptoms, they were remarkable for their absence, at least while under observation. In only one case was

there any connection demonstrated between osteocopic pains and the disease; in some there were exostoses upon the outer surface of the bone. The termination of the affection is very uncertain: they may remain stationary, be absorbed, or lead to necrosis. In many cases they lead to so-called spontaneous fracture.

DIAGNOSIS OF LUPUS VULGARIS.—Dr. Boeck, of Christiania (*Zeitschrift für praktische Medicin*, Nos. 19, 20, 21), in considering the diagnosis and treatment of lupus, points out that some of the earlier Norwegian authors did not always distinguish clearly between lupus and syphilis, a diagnosis which he regards as very easily made in the great majority of cases. He denies any causative connection between the two diseases. At the most, syphilitic parents, in conferring upon the children weakened cell- and nerve-life, may favor the development of lupus; but inherited syphilis can only be regarded as a predisposing cause.

In its treatment, the usual hygienic and dietetic rules for scrofulous subjects are to be followed; cod-liver oil is especially useful as a medicament. Locally, the following plaster is recommended:

R Ol. olivæ,

Res. colophon., aa 8 gm.;

Ceræ flavæ, 15 gm.;

Gum. res. ammoniaci,

Balsam. terebinth. venet., aa 1.00 gm.;

Acidi pyrogallici, 4 gm.

M. Fiat emplastr.

After the removal of the plaster the surface is dressed with iodoform.—*Vierteljahrs. für Derm. u. Syph.*

PAINFUL SWELLING OF THE LIVER IN YOUNG ALCOHOLIC SUBJECTS.—Mathieu considers the tender enlarged liver in young alcoholic subjects as due to chronic congestion, and believes that this is an important feature in diagnosis, especially when taken in connection with other symptoms of alcoholism. It is considered as a premonitory sign of interstitial inflammation in the liver, and therefore of importance in prognosis and in the indications for treatment.—*La France Médicale*.

SIGNS OF CONVALESCENCE IN TYPHOID FEVER.—The occurrence of multiple superficial abscesses, and that of polyuria, are two signs of convalescence in typhoid, according to Dr. Chauffard in a recent communication.—*La France Médicale*.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, FEBRUARY 10, 1883.

EDITORIAL.

MEETING OF THE ASSOCIATION
FOR THE PROTECTION OF THE
INSANE.

THE National Association for the Protection of the Insane and the Prevention of Insanity held a meeting in this city, at the College of Physicians, on January 25 and 26, which was well attended, and which showed an unexpected amount of interest in the objects of the Association. Dr. Joseph Parrish, of Burlington, New Jersey, presided at the sessions, during which a number of interesting communications were presented, for the most part by men of prominence in nervous diseases rather than by those devoted to insanity. Reviewing the proceedings, we observe, first, an address of welcome which was delivered by Prof. S. D. Gross; Dr. Traill Green, of Easton, read a paper on the "Functions of a Medical Staff of an Insane Hospital;" Dr. Charles K. Mills, of Philadelphia, contributed one on "The Duty of Medical Colleges and the General Practitioner towards Mental and Nervous Diseases;" Dr. Joseph Parrish, of New Jersey, read a communication entitled "How to Protect the Insane." In the evening, Rev. R. Heber Newton, of New York, read a paper on "Obligations of the Sane to the Insane," and Dr. H. Marion Sims, of New York, on the "Prevention of Insanity in Certain Cases of Nervous and Hysterical Women." Mr. Clark Bell, of New York, also read a communication on "The Legal Rights of the Insane, and their Enforcement." The second day was largely devoted to papers upon the relations of inebriety to insanity. Dr. T. D. Crothers, of Connec-

ticut, contributed one on the "Prevention of Insanity by the Rational Treatment of Inebriety;" Dr. Baer, of Berlin, presented one, through Dr. Carl Seiler, of this city, on "The Connection between Alcoholism and Insanity; or, the Relation of Inebriety as a Cause of Insanity;" and one was received from Dr. Norman Kerr, of London, England, on "Intemperance and Insanity." Other subjects were also considered by foreign contributors, Dr. J. Milner Fothergill being represented by a communication entitled "Do Perversions of Assimilation Play any Part in the Production of Insanity?" and Dr. James Laler, of Dublin, by one on the "Systematic Education of the Insane as a Means of Cure." There was also one on "Some of the Conditions of Life which influence the Induction of Insanity," written by Dr. Charles Mercier, of London. The last two papers were contributed by gentlemen connected with large insane institutions. With these exceptions, the meetings were remarkable for the absence of any marked evidences of interest among those personally engaged in the practical study of the treatment of the insane.

In the opening address, Prof. Gross urged that increased care should be taken in insane hospitals to have a better classification of the insane, that there should be more efficient treatment in these institutions, and that more attention should be given to the study of etiology and morbid anatomy of mental disease. It was pointed out by others, that the medical staff of such institutions, as a general thing, is not as large as would be required for proper treatment of those under its charge. The subject of women practitioners in insane hospitals was broached, and a resolution adopted calling attention to the need of gynæcologists in all insane institutions, and recommending this addition to the staff, with a preference for female practitioners for this position. An important

topic considered in Dr. Mills's address was the great need of facilities for the study of mental disease in our colleges; and a resolution was subsequently adopted, directing that a circular be sent by the Association to every medical college in the country, memorializing them upon the subject, and suggesting the immediate establishment of a course of didactic and clinical instruction in psychiatry as a part of the regular compulsory course on medicine.

The need of a faithful commission on lunacy in every State in the Union, with compulsory visitation and examination of all patients under treatment at least twice a year, was especially considered in the paper of Mr. Clark Bell, President of the New York Medico-Legal Society, who strongly insisted upon the need of early action in the matter; this view was also taken in the paper by Dr. Parrish. On motion, a committee was appointed to prepare and present a report on the proper law regarding the care of the insane; and also a committee on statistics, to keep account of the facts regarding the increase of insanity and on the condition of the insane in the United States, to report at the next meeting. Resolutions were also passed recommending regular and pleasant occupation for the insane as a remedial agency; appointing a committee to secure the passage of laws imposing penalties for issuing false certificates of insanity (similar to the Pennsylvania law on this subject); and also a committee to suggest a better name for the Association. The following officers were elected for 1883:

President.—Dr. Joseph Parrish, of Burlington, New Jersey.

Vice-Presidents.—J. S. Jewell, M.D., Chicago, Illinois; C. C. Yemans, M.D., Detroit, Michigan; E. C. Seguin, M.D., New York; Mary Putnam Jacobi, M.D., New York; C. L. Dana, M.D., New York; J. C. Shaw, M.D., Brooklyn; Hon. M. D. Follett, Marietta, Ohio; Hiram Corson, M.D., Conshohocken, Pennsylvania; Hon. R. L. Lambertson, Bethlehem, Pennsylvania; Dr. J. P. Bancroft, Concord, New Hampshire; J. C. Hall, M.D., Monroe, Wisconsin; Hon. James Perkins, Cleveland, Ohio; Dr. W. J. Morton, New York; Dr. Walter Channing, Boston; Garrett S. Cannon, New Jersey.

Secretary and Treasurer.—Miss A. A. Chevaillier, of Boston.

Executive Committee.—Dr. Joseph Parrish, Miss A. A. Chevaillier, Dr. W. B. Atkinson, of Philadelphia, Dr. C. K. Mills, of Philadelphia, Mr. Clark Bell, of New York.

A FEW FINAL WORDS ON THE PHARMACOPŒIA.

IN the last number of *New Remedies* is an attack upon the editor of the *Medical Times* because he has ventured to disagree with the Committee of Revision concerning the dismissal of certain remedies from the Pharmacopœia. From the tone of the article it is perfectly plain that any controversy might readily become personal, and at best no good could come at present out of such controversy. When the years bring the time for the appearance of the supplement, we may have more to say on this matter.

We would, under the circumstances, not have noticed the article in *New Remedies* at all, had not it clearly shown that our writing might naturally lead our readers into the error of supposing that *santonin* is not officinal.

Troches of *santonin* have been dismissed from the Pharmacopœia, and troches of *santoninate* of sodium introduced evidently as a substitute. We ought to have stated clearly that *santonin* is still officinal, although its troches are not. *Santonin* is habitually used in troches, and all that we said concerning the superiority of the old lozenge, and the danger of the new, is still as applicable as it is true.

In conclusion, though desiring to avoid controversy, we may be allowed to reply to the assertion of the editor of *New Remedies* that "it [oil of camphor] is not mentioned in any text-book upon therapeutics," and the final taunt, "Now is the opportunity for the editor of the *Medical Times* to supplement his little lecture on vermifuges with one entitled 'What I know about Oil of Camphor,'" by the statement that any one may find upon page 206 of H. C.

Wood's "Treatise on Therapeutics" the peculiar therapeutic value of the oil as contrasted with that of camphor briefly but clearly pointed out; also, that the same information is even more fully given in the article in the "United States Dispensatory," although the editor of *New Remedies* flatly asserts to the contrary. (See second paragraph, page 620, fourteenth edition "United States Dispensatory.")*

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

THE Committee of the American Medical Association having under consideration the subject of establishing an Association journal, appointed at the last meeting at St. Paul and authorized to make all needful arrangements for its publication, held an important meeting in Chicago on the 17th ult., at which final and decisive steps were taken. It is stated that a sufficient number of guarantees from members of the Association had been received to warrant the undertaking, in the minds of the committee, and it was determined that the proper measures to institute the journal shall be set on foot at once. The publication is understood to be a weekly, having something of the general style and appearance of the *British Medical Journal*,—although, it is to be hoped, printed with better-faced type; the place of publication has been also decided upon, Chicago being selected, for reasons convincing to the majority of the committee. The choice of the committee for editor is Dr. N. S.

* The exact connection of Dr. H. C. Wood with the last edition of the "United States Dispensatory" has never, so far as we know, been stated in print; and as probably most persons believe, as Dr. Castle seems to, that Dr. H. C. Wood revised the book, it is perhaps allowable to state that this is incorrect,—that up to the article "Veratrum Viride" Prof. Geo. B. Wood did the work himself. At or about the article mentioned, Prof. Geo. B. Wood's health so failed that he was forced to hand over his notes made for the remainder of the revision to Dr. H. C. Wood, who, from these notes chiefly, revised the second and third parts of the volume, carrying out as closely as he could the desires of Dr. Geo. B. Wood.

Davis, of Chicago, ex-president of the Association, and a veteran medical editor.

IT is not very often that the New York medical press has anything good to say of Philadelphia, or anything but patches and plasters to cover over the bare places and hide the sores upon the medical body politic of New York. The following sentences, culled from an editorial in the *New York Medical Record*, are, therefore, worthy of passing notice:

"But they [our societies] seem to be quite contented with their present methods, and without ambition to rise above discursive gossip over inconsequential specimens.

"Our neighbor city, Philadelphia, sets us an example that should be followed here. In the past few years a large amount of original work has been done in the pathological laboratories of that city."

The credit might, however, have been well both extended and restricted. The original work has, all of it, with the exception perhaps of one or two papers, been done in the laboratories of the University of Pennsylvania, and has been in the field not only of pathology, but also of physiology. In the aggregate, a great deal has been achieved. Much may have been talked about in New York, but much more original work with less talk has been finished in physiological and pathological directions in the scantily-furnished laboratories of the University during the last decade than in all of the remainder of the United States, not excluding Johns Hopkins University, with its unlimited means.

CORRESPONDENCE.

LONDON LETTER.

THE most enthralling medical matter at the present time is the suicide of a young medical man at Hounslow,—memorable as the place, half-way between London and Windsor, where James II. had his camp when his Dutch son-in-law had to come to the deliverance of a distracted country. The story, as I shall tell it, is not drawn from original sources, for the parties are unknown to me, but from what appears in the London

press. Therefore any guarantee of the accuracy of what is written is impossible; but from the publicity given to the matter there is little doubt that the items are correct. The sad tale is of painful interest to the profession, and illustrates a phase of medical life which will scarcely raise it in public opinion. Cases have occurred where a medical man has sold a share of a practice to a junior, and soon got rid of him at a great loss and then sold the share again to some one else. Whether this was a case in point may not be affirmed, but the facts point somewhat in that direction. The medical men in this unhappy case are not the lowest stratum of the profession by any means, but men in a good social position,—men, too, who distinguished themselves in their college career, while Dr. Whitmarsh is not unknown in medical literature. What is stated in the press has been sworn before a coroner's jury; and naught is set down by me in malice, or from any other motive, of or on my own account. Some fourteen months ago, Dr. Whitmarsh, who has for some time been settled at Hounslow, sold a share of his practice to Dr. W. W. Edwardes for the sum of eighteen hundred pounds. Recently, he states, Dr. Whitmarsh offered him five hundred pounds to leave the place and let him (Dr. Whitmarsh) retain the existing book-debts, valued at from nine hundred and fifty to one thousand pounds. Of course the young man objected to do this; and then comes out a most horrible story, how far absolutely true may not be said, but there is enough of truth in it to make it a very sad tale. The young man came home early in the morning of December 27, with the unqualified assistant of the firm, who urged him to take the five hundred pounds to turn out. When he went up-stairs to his wife, he told her that a charge had been brought against him by a female patient of assaulting her, and that his senior partner was supporting her in the charge, instead of helping him. It was arranged that next day legal proceedings should be taken to charge the precious pair with conspiracy to defraud. Instead of this, the young man went down-stairs, wrote a letter, and poisoned himself with prussic acid. His wife rushed down-stairs, hearing something was amiss, and went for a neighboring medical man, but in a few minutes all was over. Dr. Edwardes chose to meet his Maker rather than the difficulty which had overtaken him. Later on, the servant found in his drawer a letter to his wife just before the sad act was perpetrated. In this letter he says a foul charge had been brought against him by a wicked, designing woman. He said he would have met the charge had it not been for his partner, who brought pressure to bear upon him to leave the practice. This is the written statement of a man who knew that death was at hand, who had deliberately made up his mind to take his own life; and statements made

under the circumstances have ever been regarded as valid. Then he continues, after mentioning the money-proffer, "What is the alternative he offers?—that unless I go he will himself appear as a witness against me, thus assuring my conviction; as what jury could acquit a man when his own partner pretends to believe in his guilt? I am now about to appear before my Maker. I cannot live dishonored, and dishonored I shall be whether I leave the neighborhood or whether I stay to confront the perjured witness. At this awful moment, I solemnly declare that I am innocent of the charge, which has its origin in the morbid imagination of a licentious-minded hysterical woman." This is the language of a cultured man, passionate in his agony. With an ardent hope for his wife and little ones, Dr. Edwardes then made his appearance before One to whom all hearts are laid open. A coroner's inquest was held, where the wretched widow told her story, and the letter was read. When the public heard the story, its wrath was roused. A mob sacked Dr. Whitmarsh's premises, he himself having got out of the way. A strong detachment of police was required to maintain public order and to restrain the popular feeling from further demonstration and damage. Dr. Edwardes was connected with the Volunteers, and every respect was paid to his remains when borne to the grave; for in the fourteen months he had been at Hounslow he had won the good will of all with whom he came in contact. The inquiry before the coroner was adjourned for some days, and when it was resumed a medical certificate was put in that Dr. Whitmarsh was ill and unfit to attend. It was clear he was in no mood to appear and clear himself. Mrs. Edwardes was called again. Her husband had not told her at first of the charge being brought against him, as he naturally wished to spare her; but he had acquainted her father with it, he had told his senior partner, and had gone to the woman and told her her charge was false. When he did tell his wife, he produced a letter in which the woman withdrew her charge and expressed her regret that it had been made. It was signed by "Rose Bignell" and "F. Bignell" (her husband), and witnessed by "Michael Whitmarsh." Yet that night the proffer of five hundred pounds to go away and leave the practice and the book-debts behind him was urged on him while Mrs. Bignell's solicitor was at Dr. Whitmarsh's house. If he would take the five hundred pounds and go, nothing more would be said.

The poor hunted man told his wife that if it were not for her he would face a trial and take the consequences. He told her that the solicitor would take out a warrant next day, and Dr. Whitmarsh would go into the witness-box against him. Of course an older man would have taken the matter more calmly; but this poor young fellow was distracted.

He had only received one hundred and eighty pounds so far as his share of the profits for his eighteen hundred pounds. Now he was to run away, leaving his money behind him, to start life with five hundred pounds and a blackened reputation. If he did not accept this paltry sum, proceedings were to be taken against him next day. Dr. Whitmarsh had counsel to protect his interests, but no attempt even was made to break down the evidence given by the widow, who was clearing her husband's reputation so bravely. Instead of Dr. Whitmarsh appearing to explain his conduct, the unqualified assistant was put in the witness-box, and led off by declining to be sworn. When Rose Bignell's letter, charging Dr. Edwardes with assault, was read by the partners, the senior called in the assistant, saying, "We are in a pretty mess!" An ominous way of putting it to an assistant who was without a medical qualification. It was "the practice" that was injured. Mrs. Edwardes was never mentioned. Then when Dr. Edwardes went to Mrs. Bignell the charge was withdrawn; but the senior partner raked it up again when his junior declined to run away from the place with less than a third of what he had paid so recently. From that witness it seems the charge was held to be a dissolution of the partnership. Instead of boldly standing up for his junior partner and encouraging him to prosecute, and so clear up the case, the defence the senior suggests is that his precious practice would be injured, and he offers his junior a sum to get away out of the place. This is the best construction the man can put forward to explain his conduct. It is a poor paltry piece of selfishness, look at it as charitably as we may.

The solicitor for the deceased explained in court that the evening before his death the deceased had gone to his own solicitor (who was present in court) to instruct him to take proceedings against Mrs. Bignell and Dr. Whitmarsh for conspiracy. And thus the matter stands at present, the coroner having adjourned the inquiry for a week. When the widowed Mrs. Edwardes, escorted by her father, went up the street, she was respectfully greeted. A large force of police were protecting Dr. Whitmarsh's premises: where that gentleman and Mrs. Bignell have put themselves out of the way is not stated by the press. Mrs. Bignell has left the neighborhood, it seems. Dr. Whitmarsh, who is a medical officer of the Brentford Union, has written to his board of guardians intimating to them that he has made arrangements for a lengthened absence from his duties. Very lengthened it will probably be, for Hounslow does not seem a very safe place for him. Indeed, if he could hire a lodging in Newgate or Portland he would be comparatively safe from the rage of the populace. Professional opinion is very severe upon Dr. Whitmarsh, judging from what I have heard. Curiously

enough, it seems that gentleman, for a short time past, has been a recognized supporter of the Salvation Army in Hounslow, and has frequently attended their gatherings, being one of the speakers on two or three occasions. The excitement at Hounslow has been intense; policemen have been seriously injured, while damage to the residence of Dr. Whitmarsh has been done to the extent of some hundreds of pounds. The chairman of the local bench of magistrates has been threatened with personal violence if the prisoners who have been apprehended in the riots were punished. Not only had a large body of police to patrol the town while the inquest was actually being held, but a large force was required to keep order when the magistrates heard the charges of assault and rioting. A subscription had been got up to defend the prisoners, so excited is the neighborhood in the matter. One of the policemen is in a critical state with concussion of the brain. The presiding magistrate said matters had become so serious that if they showed any weakness there would be murder. The prisoner was remanded for a week, to see if the policeman would be sufficiently recovered to give evidence, bail being decidedly refused. Another has been sent to prison for a month. On Sunday, thousands of persons from London and elsewhere visited the usually quiet little place.

I do not know whether nurses in your country are assuming the attitude they are choosing to take here or not. Serious rows have taken place at several important medical institutions here in the last few years, started apparently by nurses aspiring to be superior to the medical men. I am in a position to contribute a small item to "the nurse-question," which may not be entirely without interest. Last week a call came to see a patient with a heart-affection, in the Isle of Wight. He was a comparatively young man, with mitral stenosis, and was under one of the best practitioners in England. On arrival, the patient was found in bed, breathing laboriously fifty-two times per minute, with a pulse of 120. Clearly there was considerable impairment of the lung-space, and the right lung was extensively congested. There was a good deal of fluid in the abdominal cavity, and some cedema of the lower extremities. The treatment had consisted of digitalis and acetate of potash in broom, with a sixth of a grain of elaterium twice a week. The treatment was judicious and energetic, all will admit. Nevertheless, some albumen had shown itself in the urine, and the medical man wished me to see the patient, who had previously consulted me in November last. My recent experience has told me in unmistakable accents that, when the respiration mounts up out of the normal proportion to the pulse-rate, it is well to resort to stimulants of the respiratory centre. So some carbonate of ammonia and

nux vomica were given with the digitalis and broom, and the patient was sweated with Sir James Simpson's bath (bottles of hot water in stockings wrung out of hot water, packed round the patient) as described in my "Practitioner's Hand-Book of Treatment." He perspired freely at the first bath, which is not usual, and a favorable prognosis was hazarded on the conditions that the line of treatment was carefully followed, otherwise the case would probably sink. For the carrying out of these conditions a nurse who understood what was required was essential. A letter just received says that the patient has good days, and the last two nights have been excellent (that is, after two nights of the treatment the patient begins to have comfortable rest). The respiration has fallen to 24, and the normal ratio of four to one is maintained in the pulse (96). The urine is increasing; the bowels and skin act well. These results are all that could possibly be wished. These details are given to demonstrate both what treatment can achieve, even in very unpromising cases, and to show that the *tout ensemble* of the case was one where it was very desirable that the nurse should be made acquainted with its nature, and what the presiding medical authority desired to have done, and what was to be avoided. The resident medical gentleman wrote to a well-known nursing institution, from which he had had nurses previously, asking the nurse to be sent to me for approval before being sent off. This was to give me an opportunity of judging of the woman's fitness for the case in hand, and of giving her my views of what was required of her, and how she must go on. The answer from the matron of the institution was curt, and to the effect that it was not their custom to send nurses on approval, and they were too busy to attend to the request. On the letter reaching me, it seemed desirable to know if this was mere impertinence. So a mild inquiry was made if the lady was in earnest, intimating that my private opinion was that the nurse and her knowledge were important matters in critical cases. In answer thereto the following reached me, bearing the signature of a well-known medical name, which, however, will be withheld, though exposure would do no harm, some might think. It runs, "The Lady Superior begs me to write to you to explain that it is not customary at — to send nurses on approval. If the general nature of the case is stated, the Lady Superior will do her best to send a suitable nurse." It is difficult to say whether the stupendous self-sufficiency of the Lady Superior or the blind faith in her on the part of the medical man is the more remarkable in this curious epistle. "The general nature" of a case which had bothered one of the best heads in the profession was quite sufficient for this Superior to send "a suitable nurse." The English language is inadequate to de-

scribe the impression made on me by this astounding impertinence. That a medical man could be found to pen such absurdity is almost itself incredible; but there is the signature, legible enough to be unmistakable. No wonder the nurses of this marvellous institution look down upon the medical profession, when such truckling is exhibited by a man of reputation and position. Women know the nature of men and their weaknesses; but where was the self-respect of this weak-kneed medical man, who prostituted his professional dignity before the arrogance of a self-satisfied woman and became the mouth-piece of such astounding rubbish? It is these traitors to the profession who encourage the pretensions of these Sisters, instead of stamping on them. If they would only take their feebleness out of the question, the manlier part of the profession would soon deal with these feminine hallucinations and put the nurses in their proper place,—for in their proper place they are simply invaluable. But to assume that the Lady Superior is so inspired that "the general nature of the case" was sufficient for her to send "a suitable nurse" in this instance, is ridiculous. With all due respect for her medical champion, I venture to think the case would have taxed his powers, even after he had seen it. But to contemplate the Lady Superior's vast capacities gives me a sense of humility, which those who do not like me (no small crowd) will think an excellent moral lesson.

J. MILNER FOTHERGILL.

PROCEEDINGS OF SOCIETIES.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

A CONVERSATIONAL meeting of the Society was held at the hall of the Society, December 20, 1882.

CASE OF POLYCYSTIC KIDNEY.

Dr. J. B. Walter presented, on behalf of Dr. John Sheets, a specimen of polycystic kidney, and detailed the following clinical history:

J. C., 45 years old, machinist, a large, well-developed man, moderately stout, had always been anæmic, never had suffered from any serious illness, always a hearty eater, drank moderately of malt and spirituous liquors, never was intoxicated.

During the summer of 1881 he was troubled with several violent attacks of vomiting lasting from one to three days.

February 1, 1882, he was compelled to quit work and take to his bed, suffering with frequent violent vomiting; his face was pale and somewhat swollen, and he complained of a severe pain in the region of his liver and the back of his head.

There was no enlargement of the liver; pressure upon it in some places was painful.

Passed a large quantity of urine; sp. gr. 1010; examination revealed the presence of about one-half volume of albumen. Under treatment the vomiting ceased after four days, and he returned to work.

March 2, he returned home from Macon, Georgia, ill; while there, he had been induced to take several electric baths, which he thought made him worse.

He complained of severe pain in the back and limbs, severe occipital headache, and vomiting. Temperature $97\frac{3}{4}^{\circ}$, pulse 80 and feeble. Several abscesses on the left leg which were slow to mature, several smaller ones appearing around them. Still passed a large quantity of urine; specific gravity 1010; pale straw color; containing an immense quantity of albumen.

March 9, he was so much improved that he thought medical attendance unnecessary; and, notwithstanding cautioning, he went out of the house.

March 19, he was again confined to the house, much weaker than he had been previously. He complained of the same pains in the region of the liver and in the head, together with intermittent lancinating pains in his joints, also cramps in the legs. Bowels constipated; urine passed to all appearances normal in quantity and quality. Frequent attacks of vomiting.

He remained in about the same condition until the 25th, when he became worse, suffering with oedema of the face and lower extremities. Unable to take any food; intense thirst; hiccoughs; and the characteristic odor from the skin indicating uræmia.

Urine contained one-half volume of albumen, no casts or sugar. Continued to complain of severe pain in the region of the liver, drowsiness, and sense of suffocation. Constant collection of bitter, bloody mucus in his mouth.

Pulse 90, feeble; temperature 97° ; respiration 20. During the previous two weeks the highest temperature reached was $98\frac{1}{2}^{\circ}$; lowest 97° .

He continued to grow worse until April 2, when he died. Two days previous to death he passed daily three pints of urine; after that it was drawn by the catheter.

Post-mortem, twenty-four hours after death. —Great emaciation; numerous abscesses on the left leg, still unhealed. Moderate amount of adipose and muscular tissue in the abdominal walls. Intestines distended with gas and containing a few small lumps of feces. Stomach contracted. Liver normal in appearance and consistence. Kidneys almost three times their normal size, covered with fat, and entirely covered with small cysts, from the size of a pea to that of a nutmeg, of various colors, mostly opaque.

Upon section, filled with numerous cavities, containing a straw-colored fluid, and most of

the cavities quite tense, some few of the cysts filled with a dark fluid evidently resulting from hemorrhages.

CASE OF MITRAL OBSTRUCTIVE HEART-DISEASE.

Dr. Bruen presented the following case:

This little patient is 9 years of age, and for four years he has suffered from the results of endocarditis induced by rheumatism. The special lesion consists in mitral disease, which represents principally an obstruction of the auriculo-ventricular orifice, although there is also some regurgitation. The murmurs which may be heard are—first, a presystolic blowing sound, audible most distinctly at the apex; second, a systolic murmur distributed over the mitral area into axillæ and heard at the angle of left scapula. There is also a pronounced accentuation of the pulmonary artery second sound audible at the second left costal cartilage. This sound, when accentuated, is an indication of the repletion of the pulmonary artery with blood, and the consequent increase in the arterial tension.

I wish to call special attention to the enlargement of the area of cardiac dulness.

Commencing an inch to the right of the sternum from the third to the sixth costosternal junction, and to the left of the sternum from the second rib to the seventh, in the form of a blunt triangle nearly four inches broad at apex and seven at base. The enlargement of the heart is chiefly in the right ventricle and the left auricle, though the left ventricle is also somewhat enlarged.

This enlargement has at times simulated a pleural effusion when the pulmonary suffusion has been extreme, owing to catarrhs or temporary cardiac failure. The danger in this case, as in many others of its class, is a systole from failure of the right heart. In mitral regurgitation the gradual leakage through the valves occasions a venous repletion which increases so gradually that the repletion first manifests itself by dropsy more or less general, or an impairment of intestinal digestion due to congestion of the liver or of the venous radicles of the mesenteric circulation. In mitral obstruction the venous system does not suffer from repletion until after dilatation of the left auricle and right ventricle has succeeded the primary hypertrophy of these chambers. The clinical history, therefore, of these cases is similar to that of aortic disease. In the treatment I think it is manifest that efforts must be directed to relieve the constant pulmonary repletion, and thereby lessen the chances of cardiac dilatation.

At one time in the history of the case before us, when treatment had totally failed, a copious epistaxis, which lasted for several hours, until the boy was really blanched, was brought about by picking the nose. Since then his health has been uninterrupted, and no treatment directed to his heart has been

required. Briefly speaking, the suggestion of nature was not lost upon me, and I have found that cupping, both wet and dry, has been the most satisfactory method of treatment in similar cases. I have bled adults to the extent of a pint of blood at a time, with the most happy results, but I always try the cupping first, as the less radical measure. I have not been deterred in practising this treatment by anæmia or atheroma, since the load which is carried by the right heart and lungs is always very severe, and an efficient circulation is rapidly followed by increased assimilation and nutrition. Where I have reason, however, to suspect extreme cardiac feebleness, I rest satisfied in cupping.

The other agent from which I have derived most assistance is belladonna. I will not speculate on the physiological action as explaining the happy effects of the drug, but I will suggest that by dilatation of the capillaries the arterial tension is lessened and the work of the heart rendered easier. Possibly there is a stimulative action upon the respiratory centres at the same time.

Digitalis, I believe, is useful, but chiefly as an adjuvant. As a powerful cardiac stimulant, it is helpful by increasing the systole of right and left ventricle, and it may also lengthen the diastole, and thereby the pulmonary circulation is relieved. But used without an attempt to lessen the pulmonary and right-heart repletion, it is like applying the goad to an already overloaded steed. When digitalis has signally failed in these cases, belladonna associated with some pure cardiac stimulant, as ether or ammonia, has achieved striking results, although it remains a fact that digitalis is always a valuable adjuvant.

DISCUSSION ON TREATMENT OF WHOOPING-COUGH.

Dr. Blackwood asked the views of the members with reference to the treatment of whooping-cough, and stated that in his experience little good was obtained through therapeutic measures. He was especially interested at present, as the patient was his daughter, and the attack was particularly severe at night.

Dr. J. M. Campbell said that undoubtedly the whoop was the serious feature of the disease. He had met with success by using a combination of belladonna and chloral, and had also recently used with good results ammonium picrate in doses of one-eighth to one-sixth of a grain every two or three hours to a small child. This remedy was intensely bitter, but might be given in a small pill or pellet. In the few cases tried it had not failed to break up the whoop.

Dr. Atkinson said that he had tried almost everything, and had found belladonna the best remedy, but it must be carried to its toxic effect and maintained at that point for a short time. He had used it even in very young

children. Ammonium bromide might often be advantageously combined with the belladonna; but the chief point was to secure and maintain the toxic effect.

Dr. Bartholow considered time an important element in the treatment of whooping-cough, but thought that no doubt could be held as to the efficacy of belladonna, chloral, and other agents which relieve spasm. The disease is specific, and is due to a germ as yet unrecognized, and we are therefore unable to employ specific treatment: we treat only the main symptoms. Change of location often proves of benefit, and it is not because any special curative influence exists in the new location that we have the good results, but because a change has occurred. When benefit follows taking children to the neighborhood of gas-works, it is not the ammonia which does the work: it is the change of location. He had in the same way seen children cured by a journey across the Ohio River. Among the remedies used with most success were chestnut-leaves, and cochineal, with potassium carbonate, but belladonna was the best. Until, however, we discover the specific treatment, our remedies will be at best palliative.

Dr. Blackwood, in closing the discussion, said, in reply to a question by Dr. Mills, that quinine had not been of service. Little value was to be attributed to chloral, bromides, or belladonna. More aid was had from fresh air, regulation of the digestion, and patience. He thought the transfer of the patient to another locality helped the family doctor by relieving him of that patient at least, and generally gave the physicians in the new neighborhood more to do by starting new cases. H. L.

A CONVERSATIONAL meeting of the Society was held at the hall of the Society, January 10, 1883.

DISCUSSION ON MUSHROOM-POISONING.

Dr. O'Hara asked for further information in regard to the effect of boiling the mushrooms in water.

Dr. Leffmann said that the toxicology of these articles was still in an unsatisfactory state. Most of the analyses were of little value, and the statements of different authorities were somewhat discordant. From what he had seen in reference to the subject, he was inclined to the opinion that the poisonous action was largely dependent on the conditions of soil and season, and the effect of the same species might differ greatly at different times.

Dr. Eskridge desired to emphasize a remark which had been made by both Dr. Evans and Dr. Leffmann. This was that the condition of weather influenced the character of the fungus. Farmers living in certain localities were in the habit of penning up their hogs for a few days immediately after a heavy rainfall fol-

lowing a prolonged drought, knowing that if the animals are allowed to run at large many will be poisoned by the mushrooms which spring up from the wet ground, while those fungi which grow during ordinary weather are not hurtful.

Dr. J. C. Wilson said that it is a curious fact that an article like mushrooms, which is such a favorite article of diet with many people, should be so little understood. In country houses, where the ladies of the household exercise supervision over the kitchen, several tests of safety for mushrooms are in common use. Two of these had been mentioned,—the red gills and the detachable capsule; but a third could be added; this is, that if the mushrooms while cooking blacken a silver spoon they are regarded as unfit to eat. He wished to know if this test had ever been explained on chemical principles.

Dr. Risley confirmed the remarks of Dr. Wilson, adding that freshness was of the utmost importance. The mushroom should be gathered as soon as possible after its growth, for in a few hours the gills lost their fresh pinkish tint, and the umbrella covering would no longer peel off without bringing with it masses of the underlying tissue. In his experience the silver-spoon test had always been insisted upon as a valuable addition to the indications furnished by the color of the gills and the ready removal of the covering.

Dr. Sinkler called attention to the fact that atropia in doses of about the one-hundred-and-twentieth of a grain hypodermically was recommended by Dr. Lauder Brunton, in the *British Medical Journal*, some years ago, as an antidote for mushroom-poison. He had seen a patient who was suffering from violent vomiting and purging after having partaken largely of mushrooms. Acting upon Dr. Brunton's suggestion, he had given the one-hundred-and-twentieth of a grain of atropia hypodermically, with speedy relief to the symptoms.

Dr. H. Y. Evans, in closing the discussion, said that he believed that all mushrooms contained the poisonous principle, but not always in sufficient quantity to do harm. The difference between the safe and the unsafe was one of degree only. As regards the use of atropia, he could only say that the cases he had seen and those of which he had read were all, in the early stage, marked by dilated pupil and dry throat,—the symptoms of belladonna-poisoning, which, indeed, he had at first supposed one case to be. From such symptoms he could hardly think that atropia was indicated.

DISCUSSION ON CASES OF PNEUMONIA.

Dr. O'Hara stated that when he saw the first case the cerebral symptoms were like those of cerebral exhaustion from alcoholism. It was not uncommon to find head-symptoms in typhoid fever overriding all other symptoms; and this might be occasioned by the poi-

soned state of the blood furnished to the cerebral centres. A pneumonia could in the same way cause the same symptoms. He recalled a case in which there were very violent brain-symptoms. A diagnosis of acute paresis of the insane was disputed, and the consulting physician thought that it was a brain-tumor. The symptoms were hallucination, insomnia, paralysis of swallowing-muscles, attempted suicide, sometimes hydrophobic symptoms. Upon post-mortem, hardly sufficient lesion was found in the brain-membranes to verify any diagnosis. Dr. Mills, who performed the autopsy, thought the microscope would attest changes in the brain-structure.

DISCUSSION ON DYSPEPSIA.

Dr. Eskridge said that some years ago Schiff had stated that a stomach fasting many hours, or exhausted by copious digestion, is incapable of secreting a gastric juice which is active until the gastric mucous membrane has absorbed certain substances known as peptogens, which are readily changed into pepsin. The soluble portions of meats contained in soups and broths were easily converted into pepsin, and in these forms have been recommended an hour or so before a regular meal following a long fast. Dr. Eskridge had found milk, alone or with dry bread, between meals, sufficient to prevent unpleasant feelings in many cases of minor dyspepsia.

NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, JANUARY 18, 1883.

R. F. WEIR, M.D., Vice-President, in the chair.

DR. PAUL F. MUNDE read a paper entitled "Secondary Puerperal Hemorrhage."

The possibility that alarming uterine hemorrhage may occur as late as several weeks after confinement was scarcely more than referred to by most authorities in obstetrics. The subject was treated more fully, however, in the standard works of Barker, Winckel, Playfair, Spiegelberg, and Barnes, and in an essay by Dr. Theophilus Parvin, read before the annual meeting of the American Gynecological Society for 1880.

The following case presented certain features not referred to in Dr. Parvin's paper. Dr. Mundé saw the patient, in consultation with Dr. Kohn, on August 2, 1882. She was 25 years of age, had always been healthy, and was the mother of three children. Labor began on the 16th of July, progressed slowly, and after twenty-one hours, the head almost resting upon the perineum, an attempt was made to deliver with the forceps, but failed. Delivery was effected with the cephalotribe after perforation, the trouble being hydrocephalus. Hemorrhage was pro-

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Grindelia Squarrosa.
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Guarana.
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Honduras Bark.
Horsemint.

Iron Wood.
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Jamaica Pimento Leaves.
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Lily of the Valley Flowers.
Lily of the Valley Root.
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Manzanita Leaves.
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Mistletoe.
Musk Root.
Paraguay Tea.
Pulsatilla.
Quebracho Bark.
Quinine Flower.
Rhus Aromatica.

Sabbatia Campestris.
Sandal Wood.
Sarracenia Flava.
Sassy Bark.
Saw Palmetto.
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Sierra Salvia.
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fuse, but soon ceased. The placenta was adherent to the right side of the fundus, and required to be separated by the hand. Care was taken to leave no fragments behind. The anterior lip of the cervix was torn. Two fluid-drachms of the extract of ergot were administered, and all hemorrhage ceased. With the exception of a slight elevation of the temperature and pulse, the patient seemed to be doing well for the next six days. The lochia were fetid from the third day. Uterine injections brought away small threads of coagula, and the lochia lost their offensive odor, but on the twelfth day they again became offensive, and on the sixteenth day profuse hemorrhage set in. When Dr. Mundé saw the patient, four hours later, she was almost exsanguinated. Hemorrhage had been checked for a few minutes with hot-water injections, but, recommencing, a vaginal tamponade was also applied. Dr. Mundé found the patient with low head, perfectly pallid face, hands and feet cold and clammy, pulse 120, very weak, consciousness unimpaired. The fundus of the uterus was on a line with the umbilicus, irregular in outline. He prepared some fresh carbolized tampons, procured a few ounces of tincture of iodine, filled a syringe with hot carbolized water, and then proceeded to remove the vaginal tampons. The uterine cavity was found filled with soft coagula, offensive, dark-colored, mixed with threads of decidua; the surface was soft and pulpy, and the mucous membrane seemed to be much thickened. The cavity was washed out with hot carbolized water, and half an ounce of pure tincture of iodine was then injected through a tube, introduced through the vaginal speculum with considerable force, so as to insure thorough distribution. Cotton tampons, joined with a cord, were introduced, to be removed within six hours. Hypodermics of brandy were given, and ten drops of aromatic spirit of ammonia, five drops of spirit of camphor, and a teaspoonful of brandy were ordered in ice-water every half-hour. An ice-bag was put over the uterus, and a hypodermic injection of ergot—Squibb's fluid extract of ergot—was made at the abdomen. Carbolized water should be injected into the uterus on removing the tampons, to guard against decomposition of the coagula produced by the iodine. Dr. Mundé visited the patient twenty-four hours later, and learned that there had been no further hemorrhage. The cavity of the uterus had been washed out twice. A hectic flush and a peculiar sweetish odor sustained the opinion that the patient was suffering from septic endometritis. Injections of a solution of permanganate of potash were made into the uterus every three hours. Should the temperature rise above 102° F., ten grains of the salicylate of soda were to be given every two hours, nutritious enemata, and stimulants. The prognosis was considered unfavorable. Dr. Kohn gave intra-uterine injections of a

solution of quinine, one drachm to the quart, apparently with benefit. The patient recovered slowly, convalescence being complete at the end of five weeks.

The author of the paper then reviewed some of the points of interest in the case, and spoke of the causes of secondary puerperal hemorrhage. These might be divided into constitutional and local. Under the former, hæmophilia, mental emotion, functional disease of the liver, improper use of stimulants, sudden assumption of the erect position; under the latter, irregular and inefficient contraction of the uterus, clots in the uterine cavity, portions of retained placenta or membranes, retroflexion of the uterus, laceration of the vagina, vulva, or cervix: inflammatory ulceration of the cervix, malignant disease of the cervix, pelvic cellulitis, involution of the uterus, premature sexual intercourse, loaded rectum, distended urinary bladder, malarial poisoning, and general febrile disturbances were also causes of secondary metrorrhagia. His own case belonged to the class in which there was disease of the inner surface of the uterus, chiefly endometritis.

The time at which secondary hemorrhage was liable to occur varied with the character of the labor, the care taken at the third stage, the precautions during childbed, and accidental circumstances. Barker referred to cases as late as the fifth or sixth week after labor, and Helfer to one on the fourth week; but it occurred very rarely later than the fourteenth day. The after-effects of protracted secondary hemorrhage were its debilitating effects upon the woman, and subsequent uterine disease of some kind or other. After referring to points in the treatment of this case, Dr. Mundé concluded his paper with remarks on the means of preventing primary and secondary hemorrhage after labor. With regard to the third stage of labor and the early puerperal state the following rules were given:

Always keep the hand on the fundus uteri from the moment the head appears at the vulva until the placenta is expelled.

Do not hasten the expulsion of the placenta too much.

Watch the uterus with the hand, using gentle friction occasionally, for at least one hour.

Always give ergot immediately after the birth of the child.

If the uterus shows reluctance to remain contracted, rub the fundus gently with a piece of ice, or insert a cone-shaped piece into the cavity.

Always make sure that the uterus contains no coagula.

Apply the child to the breast early.

Apply an equably tight binder, and, if there be tendency to hemorrhage, a pad should be placed over the fundus.

If there be laceration of the cervix or of the vagina, future oozing may be checked by

mild astringent injections, or by applications through the speculum. Immediate suture for laceration of the cervix was not considered feasible.

Do not allow the lying-in woman to leave her bed before the tenth day.

See that the bladder is empty and is not interfering with uterine contractions.

See that the nozzle of the syringe is not introduced too far, and that too much force is not used in giving the customary cleansing injection.

DISCUSSION.

Dr. W. M. POLK, on invitation, opened the discussion, and referred to a case of profuse secondary hemorrhage which occurred on the fifteenth day after confinement. The tampon was applied because the uterus was not large and was firmly contracted. From negligence on the part of the nurse, complete atresia of the vagina was produced by the iron styptic, for which a secondary operation was afterwards performed. Dr. Polk referred to the causes of secondary puerperal hemorrhage under the head of constitutional and local, to the former belonging cachectic states, such as from malarial or mercurial poisoning, etc., and to the latter the various septic inflammations belonging to the uterus, etc. He did not approve of the bandage and compress as generally applied. He preferred hot to cold water injections against hemorrhage. Immediate operation for laceration of the cervix was considered out of place.

Dr. E. L. PARTRIDGE spoke specially with reference to previous conditions which, after labor, interfered with proper uterine contraction, predisposing to secondary hemorrhage, and then referred to a case of hemorrhage which occurred on the ninth day after delivery, due to an annular slough involving the entire vaginal end of the cervix. The hemorrhage was so profuse that the patient's life was in jeopardy. The history of the case was one of early rupture of the membranes. He thought the tampon should not be resorted to until other means for controlling hemorrhage had proved ineffectual, although in a case like that of Dr. Mundé he would not hesitate to employ it. The danger was from absorption of septic material.

Dr. H. T. HANKS referred to some cases of undoubted malarial origin. In one case which occurred on the fourteenth day profuse hemorrhage was controlled by the battery and hot-water injections. He did not approve of the tampon, and thought also that it was not necessary in every case to give a drachm of ergot after the birth of the child. He agreed with nearly all the remarks made by Dr. Mundé.

In closing the discussion, Dr. MUNDÉ remarked that it was certainly a risky practice to introduce the tampon in these cases, but it was necessary in this instance to guard against the loss of another drop of blood.

Dr. E. B. BRONSON then read a paper on "Eczema, its Pathology, and the Principles of its Treatment."

The author of the paper believed that the epidermis rather than the vascular layer beneath was primarily involved in the disease, and referred to recent investigations going to show that the epidermis as well as the papillary layer was supplied with nerves. The itching which took place in the course of the disease was probably due to disorder of those nerves, the pathological anatomy of which, however, was not much known.

The therapeutic indications were to allay irritation and assist repair, and consisted in measures of rest and stimulation. Local applications were either mechanical, chemical, or dynamic. Wet applications were best for the higher grades of eczema. Astringents, alkalies, or powders might be applied in lotions. Undiluted glycerin acted as an irritant. Later was the period for emollients, and afterwards that for ointments. The zinc oxide was the best protective ointment. Absorbent cotton or lotion was better in cases of erosion with copious discharge.

Among the agents which modified vital action were the alkalies, which had a sedative influence upon the sensitive nerves. The strength of the alkali employed should vary according to the age or severity of the case. The soap treatment was the most effectual for squamous eczema. Pruritus might be relieved by continued hot-water applications.

Carbolic acid and the tar preparations should not be employed in the stage of active exudation. Mercurials should be employed in later stages, when the accumulations occurring in the progress of the inflammation interfered with nutrition.

The internal administration of medicines might be of some service in diminishing reflex irritation, in restoring the general tone of the system, and in aiding local remedies. The most rational course of treatment was that directed to the skin itself, for eczema was essentially a local disease. In general, the narcotic series of remedies were to be condemned.

DISCUSSION.

Dr. R. W. TAYLOR agreed with Dr. Bronson in the main, but there was a little tendency in some parts of the paper towards the theoretical. He was not prepared to accept the view that the disease in its commencement was altogether above the rete mucosum. With regard to treatment, soothing applications in the erythematous stage, such as lead with opium, etc.; later, stimulation, and this was an important factor in most cases. Alkalies had a wide field of usefulness, and potash solutions would sometimes succeed where the soaps would fail. He was glad to know that the author of the paper had rejected the idea of diathesis. He referred to a tendency to eczema acquired in early years, when the disease was not prop-

erly attended to. Local measures were most important in the treatment, but in many cases decided benefit was derived from the internal administration of arsenic.

Dr. BULKLEY considered the paper as one of the best *exposés* of the subject of eczema which had been written. The subject of the alterations in the cellular layers of the skin had not received in years past the attention which its importance demanded. It was certainly true that the skin sometimes took on a tendency to eczema which lasted for a lifetime. He did not believe in diathesis. The part played by the nervous system should be borne in mind in considering the etiology of the disease. He did not believe that persons who were sufferers from eczema were in perfect health in other respects. He had reported cases which were greatly benefited by Fowler's solution without other treatment. He did not, however, believe that there was any specific for the affection.

NEW YORK COUNTY MEDICAL SOCIETY.

STATED MEETING, JANUARY 22, 1883.

DAVID WEBSTER, M.D., President, in the chair.

THE scientific paper of the evening was read by Dr. ROCKWELL, on "The Differential Indications for the Use of Dynamic and Franklinic or Static Electricity."

The author remarked that when a distinguished professor could say to a large class of students that a simple faradic apparatus would practically answer every purpose in medical electricity, he thought it was in order to discuss the subject. To state that electricity had been used in a given case conveyed but little meaning, unless the kind of electricity and the manner of its application were mentioned. It was not, however, to be supposed that one form of electricity only was appropriate for one kind of disease, a second for another, and a third for still another. There were, nevertheless, certain pathological lesions which demanded only a certain kind of electricity, other kinds being useless or injurious. Hemiplegia, for instance, accompanied by exalted muscular contractility, called for a mild and rapidly-interrupted faradic current, if for any form of electricity whatever. Indeed, the same current was usually preferable if the muscular contractions were only somewhat less readily called out than in the normal state. The galvanic current was indicated when there was very great diminution of electro-muscular contractility. In most cases of paraplegia, either complete or proximate, loss of farado-muscular contractility exists at least for a short time, and the galvanic current alone is applicable. The faradic current might be useful in attempting to improve impaired nutrition of the paralyzed members.

The constant current was alone applicable for directly affecting the central nervous system. In nearly all cases where electricity was indicated, each one of its forms—faradism, franklinism, or galvanism—might at one time or another possess positive value over the others.

In the great majority of cases of neuralgia where firm pressure over the affected nerves aggravated the pain, the galvanic current was indicated; if pain was not increased by pressure, the faradic current should be used. Hysterical hyperæsthesia called for the faradic current. While it was impossible in many diseases to say that a particular current was indicated to the exclusion of others, it was possible to name a variety of conditions where, as a rule, one method of treatment with one form of current was superior to others. The faradic current was indicated for its tonic effects in cases known as general debility. Not much was to be said of individual conditions which seemed to demand the faradic current alone. But few distinct organic or functional diseases in every phase of their manifestation always demanded a single form of electricity. Asthenopia accompanied by hyperæsthesia of the retina and ciliary nerves seemed to demand the faradic current alone. Galvanism was of little service for the paralysis following diphtheria. Cases were then referred to.

Galvanism was particularly indicated in special irritation or neuralgia, and in certain neuralgic sequelæ of cerebro-spinal meningitis; it was also indicated in exophthalmic goitre, and in the restoration of the senses of taste and smell, and was superior to faradism in the treatment of skin affections; the author believed it preferable in the treatment of extra-uterine pregnancy. The form of electricity indicated in chorea varied according to the general condition of the patient,—central galvanism in those who were well nourished, and general faradization in those whose general condition was impaired. The same rule held in amenorrhœa. The galvanic current was more frequently indicated in dysmenorrhœa.

Franklinic electricity was less efficacious as a constitutional tonic than was general faradization properly applied, but it was a valuable supplement. The pain of muscular rheumatism was relieved by franklinism sooner and more effectually than by other methods. It acted best administered by roller. Franklinism was superior to either galvanism or faradism for relieving pain of a chronic character, confined to no special nerve-trunk, with no tenderness on pressure; it was also frequently most efficacious in enlarged joints of subacute and chronic rheumatism, and in facilitating absorption in chronic synovitis. It should be employed in the form of sparks. Franklinism was often superior to other forms in old contractures and in cutaneous anæsthesia. Valuable as was franklinic electricity,

it had a more limited field of usefulness than dynamic. He who began with franklinism to study and practise medical electricity began at the wrong end.

DISCUSSION.

Dr. A. JACOBI coincided with most of the statements contained in Dr. Rockwell's paper. He had not had any experience with franklinic electricity. There was one class of cases of diphtheritic paralysis which proved fatal unless treated speedily and effectively. He referred to those in which there was paralysis of the respiratory muscles,—the only class of cases in which he had seen a fatal termination, with the exception of a few where the muscles of deglutition were paralyzed and foreign bodies entered the respiratory passages. For these cases of paralysis of the respiratory muscles following diphtheria, the faradic current frequently repeated was often of a great deal of benefit.

Dr. L. A. SAYRE said that Dr. Rockwell's paper was so complete and comprehensive an *exposé* of the matter to which it referred that he could add nothing. His experience corroborated all the statements therein contained.

Dr. GARRISH fully endorsed the paper. He thought that the majority of practitioners began the use of electricity at too early a period in disease. He did not regard it as of value in the acute stage. In certain cases of drowning he had found electricity of benefit in restoring life, aided by hypodermic injections of aqua ammoniæ.

Dr. A. JACOBI thought that the statements contained in Dr. Rockwell's paper would bear him out in the inference that, in all affections of the vaso-motor system and diseases in which the trophic nerves were involved, galvanism, as a rule, was preferable. He asked Dr. Rockwell if this broad statement coincided with his views.

Dr. ROCKWELL replied that, as a general law, it was true, but he doubted whether it could be made absolute. For instance, take a case of facial paralysis due to cold, rheumatism in character. One would hardly call this an affection of the vaso-motor nerves; and yet the galvanic current was the one which was most beneficial. No contractions were obtained in such a case with faradism, which came into play only later as a general tonic. He thought, however, that the rule enunciated by Dr. Jacobi was applicable to nearly all diseases.

Dr. JACOBI thought that the exception mentioned by Dr. Rockwell might come under the general law, if we knew exactly what the condition was in these rheumatic cases. In most of them there was probably in the beginning a disorder of the circulation also.

Dr. ROCKWELL remarked that probably there would be to some extent. His idea was that in cases of facial paralysis the inter-

muscular nerves were affected, and therefore the galvanic current was used, which acted upon these fibres altogether. It had been supposed that the faradic current caused contractions through these nerves, and hence when they were affected by the rheumatic poison this current would produce no effect whatever.

Dr. JACOBI further remarked that these cases were, as a rule, mild cases, those in which the nerve-substance itself was not affected, but the circulation, and hence a speedy recovery took place.

Dr. MITTENDORF referred to his experience with electricity in ophthalmic practice. In cases of paralysis following diphtheria, much more benefit had been derived from the faradic than from the galvanic current. The indirect current was also of marked benefit in cases of intense and disagreeable pain experienced by patients with weak internal recti muscles. According to general doctrines, perhaps the galvanic current would be indicated. On the other hand, in those cases which depended upon malnutrition of the optic nerve, cases of amblyopia due to excess of tobacco and alcohol and to the loss of blood, most benefit was derived from the galvanic current. He supposed the explanation was the influence produced upon the blood-vessels themselves, and consequently upon the nutrition.

THE PRESIDENT remarked that in amblyopia, asthenopia, etc., he had obtained little benefit from the use of electricity, and had about abandoned its use.

Dr. W. M. CHAMBERLAIN had derived decided benefit from the use of the faradic current in Bell's paralysis, but probably without feeling that he fully understood the differential indications for its use.

The paper was further discussed by Dr. LEWIS, who referred to certain cases of diphtheritic paralysis treated by electricity, and by Dr. JACOBI, who had used it in the treatment of strictures with entire satisfaction. In general, he always took pains to study the condition of nerve-degeneration, employing, after Erb, the galvanic current in cases in which there was nerve-degeneration, and the faradic current when nerve-degeneration was not present.

RESIGNATION OF THE STEWARD OF THE PENNSYLVANIA HOSPITAL.—Mr. William G. Malin, who has been for the last thirty-five years steward of the Pennsylvania Hospital, in the Department for the Sick, has tendered his resignation to the board of managers on account of failing health. He has served the institution long and faithfully, and has earned the esteem of all who have been brought in contact with him, as he has commanded universal respect. For many years he acted as librarian to the institution, and he compiled the first catalogue of the medical library.

REVIEWS AND BOOK NOTICES.

MICROSCOPICAL MORPHOLOGY OF THE ANIMAL BODY IN HEALTH AND DISEASE. By C. HEITZMANN, M.D., late Lecturer on Morbid Anatomy at the University in Vienna, Austria. With 380 Original Engravings. 8vo, pp. 849. New York, J. H. Vail & Co., 1883.

It is quite impossible, in the space at our disposal, to give a critical review, or even an adequate notice, of this extensive and meritorious work, written by Dr. Heitzmann and his pupils. We can only allude to its contents and to some of its features which more particularly impress us. The section on "Methods," by Dr. Heitzmann himself, includes directions for the preparation and study of tissues. They are those which are usually practised to-day, and are, generally speaking, a safe guide to the worker. We would not infer, however, that Dr. Heitzmann has had much experience with what he terms "manifold staining," for, while the instances may not be very numerous where it is of advantage, such instances do occur, and any one who has seen the exquisite preparations by Dr. J. Gibbons Hunt, prepared in this manner, will admit it. We are more in accord with him in what he says against the projecting of images on screens by complicated apparatus, and on the photographing of specimens, although these are also, at times, useful.

In the second section, Heitzmann deals with "the general properties of living matter," opening the subject by a paragraph on its chemistry. He adopts the term "plastidule" for the molecule of living matter, "the smallest particle, which can never be seen, even by the highest magnifying power,"—the term "plastid," suggested by Elsberg, being retained for the "cell." There can be no objection to the former word, as it is desirable to have a special term for the organic molecule to distinguish it from the "atom" of inorganic matter. Motion and reproduction are the distinctive properties of living matter.

The "arrangement of the living matter in protoplasm," and "phases of development of living matter," are reprints of papers published in the German by Heitzmann in 1873. The latter is based upon a study of amoeba, cartilage cells, and bone corpuscles, from which he concludes that the protoplasm shows differences according to age; that the youngest protoplasm is structureless with our present means of demonstration, and that the first differentiation is an accumulation of liquid in vacuoles, owing to which the living matter assumes the shape of a frame-work; still later a net-work results which occupies its peripheral portion, the central or nucleus remaining homogeneous; later still the nucleus is differentiated

into a frame-work and reticulum, leaving smaller compact centres, the nucleoli. Heitzmann says "the present generation of histologists will very probably never realize the harm done by the misnomer 'cell,' so firmly established during the last forty years;" and the proposition to the proof of which all his energies are directed is that there is no such thing as an individual cell in the tissues, as all cells prove to be joined throughout the organism, and what was formerly thought to be a cell is, in his present view, a node of a reticulum traversing the tissue. We have not space to consider this proposition, *pro* or *con.*, and must refer our readers to the volume for the argument. To one, however, who has studied and, as it were, handled cells, or at least the lumps of living matter which have been so long called cells, it must be a very convincing argument which will prove to him that it is not a distinct physical element. Besides substituting the word "plastid" for cell, he adopts that of "bioplasm" for "protoplasm," a change also suggested by Elsberg.

In the matter of diagnosis by the microscope Dr. Heitzmann claims for it extraordinary powers,—powers which if claimed by most physicians would stamp them as unpractical enthusiasts. He claims to be able to distinguish the "excellent," the "good," the "middling good," and the "poor" constitution by peculiarities of the pus and white blood-corpuscles recognizable by powers of from five hundred to eight hundred diameters; "to be acquainted with the anatomical features characteristic of tuberculosis, recognizable not only in single corpuscles, but from the peculiar aspect of the colorless corpuscles in every fresh drop of blood;" that life-insurance should be based upon microscopical examination as well as auscultation and percussion; and that marriages should be allowed, in doubtful cases, only upon the permit of a reliable microscopist. Surely such claims by almost any one else would be set down as outright quackery. But let him not be judged before a trial. There are certainly others competent to verify or deny such pretensions; and a hundred workers should at once turn their microscopes to this field with a view to settling the question. Should Heitzmann prove correct, Koch's discovery of the so-called *Bacillus tuberculosis* is trifling in importance, compared to his. Should he be wrong, his reputation as an interpreter of appearances will be forever shaken.

Heitzmann's ideas as to the importance of the pencil to the microscopist are undoubtedly correct, and are well sustained by the admirable and seemingly accurate illustrations to the various papers which make up the book. Elsberg's paper on the Structure of Blood-Corpuscles, Heitzmann's on the Tissues in General, Heitzmann and Schöney on Connective Tissue, Heitzmann and Holbrook on Muscular Tissue, Heitzmann on Nerve Tissue,

Epithelial and Endothelial Tissue, including the vascular and lymphatic systems, are complete and superbly-illustrated papers,—in fact, masterpieces. The same may be said of the paper on Inflammation.

The section on Tuberculosis is a translation of a paper published in the German by Heitzmann in 1874 in the *Wiener Med. Jahrbücher*, to which he says he has little to add. We are inclined to think some additions might have been made which would have given it greater completeness.

The subject of "Tumors" is discussed by Heitzmann himself, and he claims only to present the outlines of oncology based upon the study of actual specimens in his own laboratory. He adopts a histological basis of classification, and illustrates by excellent drawings many varieties of tumors. He prefers the term myeloma to sarcoma. The sections on the Skin, Digestion, Respiratory and Urinary Tract, are treated by the author in the main, while certain sub-subjects are handled by his pupils. Bödecker furnishes an exhaustive article on the Teeth, also well illustrated, and Dr. Frank Abbot one on Caries. Millard has an excellent and well-illustrated section on the Minute Anatomy of the Epithelia of the Kidney, an abstract of his paper published in the *New York Medical Journal* for June, 1882, and Alfred Meyer another on Acute Inflammation of the Kidneys. The urine is treated by Heitzmann himself; also the male and, in part, the female genital tract, to which Jeannette B. Greene, M.D., adds "Microscopical Studies of the Catamenial Decidua," and J. W. Franke, M.D., furnishes a contribution to the History of the Development of the Human Decidua.

Whenever Heitzmann confines himself to the description and delineation of appearances found under the microscope, he is, in our opinion, unsurpassed. In his reasoning and deductions, we confess, he is, to say the least, eccentric, if not visionary. But the volume is a truly creditable one to all concerned in it,—is, indeed, a great work. It is a storehouse of facts valuable alike to the practical physician and the teacher. On the other hand, on account of its special character and the high powers invariably employed, it is hardly suitable as a working guide for students. J. T.

LEGAL MEDICINE. By CHARLES MEYMOTT TIDY, M.D. New York, William Wood & Co., 1882.

This work, in the form in which it lies upon our table, is one of the well-known Wood's Standard Medical Authors series, and abounds in all the evidences of cheapness which mark that well-known series,—a cheapness which may well be pardoned when the small cost of the publications to the profession as well as to the publisher is remembered. We have carefully looked through the two volumes, and find that they are

based upon much careful work, are well put together, and constitute a valuable contribution to the literature of the subject. The great number of illustrative cases lends a special interest to the various chapters. The sin of the author—if he have any—is rather that of omission than that of commission. What is present is good enough, but what is away is missed badly. Only a part of the ground is traversed. Testamentary capacity, and, in fact, all medico-legal questions connected with mental states or acts, are ignored. Nothing whatever is said about rape, bastardy, and various other important matters. A line in the preface leads us to suspect that in these volumes (or this volume, as it was in the original English edition) the author has only in part carried out the task he has set himself, and that in a second publication he expects to complete his undertaking. In other words, we judge that Dr. Tidy is trying the experiment of publishing a two-volume work, one volume at a time. We trust that this is so, and that on some future occasion we may announce the completion of the enterprise.

A MANUAL OF HISTOLOGY. By THOMAS E. SATTERTHWAIT, M.D. New York, William Wood & Co., 1882.

This manual is a second edition of a well-known book, but does not seem to be a second edition in the usual sense of the work, but a reprint from stereotype plates which have had errors in them corrected, with the addition of an appendix containing discoveries made since the date of the first publication.

GLEANINGS FROM EXCHANGES.

THE BACILLUS IN PHTHISICAL SPUTA.—After giving in detail the recent methods of detecting bacilli in sputa, proposed by Koch and Ehrlich, *The Medical Times and Gazette* considers especially a report (*Berl. Klin. Wochens.*, No. 45) made by Balmer and Fraentzel, in which are communicated the results of observations upon one hundred and twenty cases where the sputa were examined. It is claimed that not only does the bacillus thus discovered clinch the diagnosis of phthisis, but the characters of the lowly organisms are a guide to the sort of case and to the prognosis. Where the find of bacilli is large, and the organisms are well developed, we are concerned with a severe case of tuberculosis, and the prognosis is proportionately bad. The number of bacteria detected in the tubercular sputa of an individual case is not constant; it waxes and wanes with the disease, being most numerous when the destructive processes are at their worst, and reaching its maximum *sub finem vita*. Sometimes the microzymes are generally disseminated in the sputa; sometimes they are arranged in groups; sometimes they

are plenteous, and sometimes scarce; and they may be discovered when the morbid process is very chronic, or even at a standstill, although then their numbers are much thinned. In rapidly-progressing cases the formation of spores is seen to great advantage. These are facts and inferences brought to light by investigations on one hundred and twenty various phthisical individuals. The presence, numbers, and appearances of the bacilli in the expectoration will be seen to tally with the nature, course, and characters of the pulmonary mischief. The life-history of the bacilli, as manifested in the sputa, forms, as it were, a complete interpretation of the processes that go on in the lung, in the same fashion as a system of words is the counterpart of a train of ideas. Such results, we think, should *a priori* have been expected, if the notion that the micro-organisms are the cause of the affection be true. We suppose there can be no reasonable doubt that the observations and inferences therefrom are correct; but, that aside, it is quite possible that the evolution and involution of the bacteria in the sputa may proceed without there being necessarily a total causal relationship between the germs and the disease,—just as the noise from a cataract may increase and decrease merely as a companion to the varying mass of water rolling, without having anything to do with the cause of the variation in the quantity of water.

THE ABSORPTION OF NUTRIENT ENEMATA.

—Dr. Charles L. Dana, of New York, communicates to the *Medical Record* the results of a series of experiments upon dogs, made to determine the physiological process by which nutrient enemata are absorbed. He finds that large injections forcibly administered may cause a "retrostasis," which will carry the material by the ileo-cæcal valve, and even into the stomach; moreover, that, in dogs, ordinary nutrient injections of two, three, or four ounces pass back some distance, and may even reach the ileo-cæcal valve, but do not go farther, the injection being carried back much better when the lower bowel is empty or comparatively so. He believes that the clinical cases are exceptional in which retroperistalsis occurs, and concludes that the process is usually effected by local absorption. The fact that the colon is very vascular and has a large supply of lymphatics confirms the view that it is not an excreting organ, but its function in man is that of absorbing: in solidipedes it has a powerful digestive action. He observes that albuminous food, when injected, speedily undergoes chemical changes and decomposition. In some of the early stages of this process it is quite possible that the changed albumen passes into the surrounding vessels. Normal peptic digestion is only a decomposition with many stages in it, during some of which the albuminous matter is absorbed. It

is not necessary that albumens be made perfect peptones before they can diffuse into the blood-vessels and lymphatics. Fats cannot be absorbed to any great extent in the colon or rectum. It is not necessary to inquire whether starches can be changed to glucose, since it is always possible to add some form of animal sugar to the enema if that be thought necessary. Milk and beef-tea are regarded as very nearly as effective as the expensive peptonized preparations for use in nutrient enemata, the value of which may be regarded as established both by physiological experiment and abundant clinical experience.

ALLOCHIRIA.—A peculiar sensory disorder, in which peripheral irritations upon the surface of the body or extremities are felt as if coming from the opposite side,—that is, a sensory impression is referred not to its proper locality, but to a corresponding one on the other half of the body,—was termed by Obersteiner, of Vienna, "*allochiria*" (*ἄλλος, χεῖρ*). It has been noticed most frequently in cases of locomotor ataxia, though not restricted to cases of spinal sclerosis, and has been found to be associated with disease, inflammatory in character, of the posterior horns of gray matter. Anæsthesia is not a necessary concomitant of allochiria; but where there is a lesion of both posterior horns at a different level, there may be anæsthesia upon one side and allochiria upon the other. The character and symptoms of this peculiar nerve-disorder have recently been considered in a paper read before the New York Neurological Society by Dr. Hammond, in which the symptoms, morbid anatomy, and mode of production of the disease are explained by references to the physiology of the gray matter of the cord and of the mode of perception of sensory impressions.—*New York Medical Journal*.

CAFFEINE IN HEART-DISEASE.—Caffeine has been largely employed as a diuretic, but it has been little used for its action on the heart. Lépine asserts that it is capable of producing the same effects as digitalis, over which, in some cases, it has decided advantages. It is, however, necessary to employ it in large doses, from sixty centigrammes to two grammes per day. The effect is more rapid than that of digitalis; in less than twenty-four hours the pulse will fall from 160 to 100 or 80 per minute, and the force of the heart's contractions is increased in just the same way as with digitalis. Caffeine is, however, better borne, and seems to be eliminated more rapidly, than digitalis. Among its inconveniences, however, are the occasional production of insomnia and a nervous condition which renders it necessary to suspend it. M. Lépine has never given it for more than ten days. Another objection is its very high price. A Paris physician, M. Huchard, has also praised it highly in the same cases, and in similar doses, especially for its

diuretic effect. Coffee is, it may be noted, an old remedy. Zwinger recommended it in 1725 for dropsy, and Honoré in 1846 for albuminuria.—*Lancet*.

GIACOMINI'S PROCESS OF PRESERVING BRAINS.—The fresh brain, in its membranes, is placed in a saturated solution of chloride of zinc, in which it floats, and must be turned over two or three times a day. After forty-eight hours, the membranes must be removed, without taking the organ out of the fluid. Allow it to remain in this fluid until it ceases to absorb, as shown by its remaining at the same level, and not sinking; then remove it, and plunge it in alcohol of commerce, where it must remain for a period of not less than twelve days, during which time the spirit should be changed two or three times. When removed from the alcohol, it is to be placed in glycerin of commerce, to which one per cent. of carbolic acid may be added. At first it floats in the glycerin; but, as the spirit evaporates, and the glycerin penetrates it, it gradually sinks to the level of the surface of the fluid, when it may be removed, put aside to dry for a few days, and, lastly, coated with several layers of gum-elastic varnish, or marine glue diluted with a little alcohol.—*British Medical Journal*.

POISONING BY TEN GRAINS OF MORPHIA TREATED SUCCESSFULLY WITH ATROPIA.—A woman having swallowed ten grains of morphia was found one hour later completely unconscious, with feeble and irregular, sometimes gasping, respiration, face flushed and cyanotic, eyes injected, pupils moderately contracted, pulse 100. After a few irregular inspirations there was an interval in which breathing entirely stopped for ten or fifteen seconds. A hypodermic injection of atropia (one-thirty-fifth of a grain) was given by Dr. E. Stuver (who reports the case in the *Medical News*), and an hour later another was given of one-fortieth of a grain. After each injection an improvement in breathing and pulse took place, but unconsciousness did not leave her until another hour had passed. With the exception of a sick headache the next morning, she recovered rapidly and without further unfavorable symptoms. The patient was in the seventh month of pregnancy, but did not abort. This case, while it shows that atropia is a useful antidote to morphia, also emphasizes the view that the size of the pupil does not indicate the gravity of the toxic effect of the morphia.

APOMORPHIA IN ACUTE POISONING.—Attention is called by Dr. Routh to the use of this valuable agent in cases where prompt emesis is desired. Two instances are reported—one of oxalic-acid- and the other of alcohol-poisoning—in which hypodermic injections of (one-fifteenth to one-tenth of a grain) apomorphia produced emesis in about

three minutes. The convenience of this mode of emptying the stomach over the use of the tube is evident; moreover, a stomach-pump is not always to be had. [The certainty and rapidity of the action of the drug are especially useful in all cases where it is desirable to produce vomiting without introducing the agent by the mouth. As regards its safety, some cases of serious collapse have been reported following the administration of the usual dose. A certain amount of care, is therefore, to be advised.]

REMOVAL OF GOITRE, WITH A FATAL RESULT.—In the *Deutsche Med. Zeitung*, No. 42, an abstract of a case of extirpation of a goitre, performed by Von Riedel, is given, which is unusual in the fact that symptoms supposed to be due to some affection of the vagus occurred soon after the operation. Aphonia, with rapid pulse and dyspnoea, set in within two hours after the operation. Tracheotomy failed to relieve the dyspnoea. Four days later pneumonia was detected, and the patient succumbed. At the autopsy the recurrent nerves were found to be embedded in blood-clot; there was also commencing suppurative inflammation of the mediastinum and lobular pneumonia. Von Riedel puts the vagus symptoms down to the use of a two-per-cent. solution of carbolic acid with which the wound was washed out. He has seen one other similar case. The facts of the case are interesting, but we think the explanation not free from objections.—*Medical Times and Gazette*.

CENTRAL AMBLYOPIA IN DIABETIC PATIENTS.—At a late meeting of the Ophthalmological Society of the United Kingdom, four papers were read upon the amblyopia of diabetics, containing notes of cases. Nine cases were referred to by Dr. Edmunds and Mr. Nettleship of failure of sight with central scotoma in the subjects of diabetes, without observed ophthalmoscopic changes. Most of the cases were smokers. The optic nerve of one of these, in which no altered ophthalmoscopic appearances were detected, showed, upon section, changes extending through the length of the nerve, but limited to a central group of fibres, in which there were observed thickening of the connective tissue and degeneration of the nerve-filaments.

THE TREATMENT OF HYDRARTHROSIS.—In a Paris thesis, Dr. Delbreil recommends rest in bed, blisters, and compression in the treatment of hydrarthrosis. Aspiration should be performed in obstinate cases; and if the effusion still persists, threatening the integrity of the joint-structures, iodine injections are suggested. In addition, antirheumatic treatment will be sometimes needed; and, in all, hygienic means play a prominent part.—*Bulletin Général de Thérapeutique*, September 30, 1882.

MISCELLANY.

THE BILL PROPOSED BY THE BOARD OF SPECIAL COMMISSIONERS.—The special commissioners appointed by Governor Hoyt to inquire into the treatment of the insane in the State have reported a bill to the Legislature. The bill creates a Central Board, to have supervision over places where insane persons are under treatment, said board to be composed of the Board of Public Charities and three additional members, appointed by the Governor, one of whom shall be a member of the bar, and another a physician, both of ten years' standing and practice. In consultation with the Chief Justice of the Supreme Court and the Attorney-General, the Committee on Lunacy is to act as a licensing board. All pay places, where insane patients are treated, must take out license under regulations prescribed by this committee for the conduct and control of such establishments. The committee have power to enforce their regulations by suspending the license upon disregard of their rules, and such withdrawal of license lays the offending parties open to a charge of misdemeanor, and any institution of the kind that fails to take out a license commits a misdemeanor. Actions for damages can also be brought against them. Medical records and "case-books" are to be kept in such establishments, with weekly and other periodic records and notes, thus preventing inmates of long standing from going out of sight.

An important section of the bill is that which requires one notice of the fact to be mailed to the Committee of Lunacy and another to the Secretary of the Board of Visitors for the county within forty-eight hours after the admission of a patient into any such establishment. The committing physicians must be medical practitioners of five years' practice, and their certificate must be given within a week of the commitment. A medical practitioner, chosen by the patient or his family, and with the sanction of a judge of a court of record, shall have access to and visit the said "lunatic" at reasonable hours. Boards of Visitors for each county are to be appointed by the Committee of Lunacy, to act in conjunction with them. Women may serve on these boards. Every institution in the State that comes under the provision of this law is to be visited once a month by a county visitor or committee member, once in six months by a committee of three, one of whom must be of the Lunacy Committee, and once a year by a majority of the committee. Any such institution that does not take out a license or fails to comply with its provisions is liable to the charge of misdemeanor. The act deals also with the criminal insane, and provides that such persons, when pronounced cured, shall be turned over to a place of custody, and not discharged upon the community

without legal release. The release of the Committee of Lunacy for all other cured cases is to be equivalent to, and, in the absence of release by the superintendents of such asylums, would actually be, a sufficient discharge.

KAIRIN.—A new alkaloid, called "kairin," is about to appear in the drug-market, for which are claimed antipyretic properties, unaccompanied by the slightest tendency to produce local irritation. It is proposed as a substitute for chinoline, itself a substitute for quinine. Drs. Fischer and Wilhelm König, of Munich University, assisted by Professor Filehne, of Erlangen, have found that those hydrides of chinoline, in which the nitrogen atom is in direct combination with the carbon atom of a methyl group or of another alcohol radical, all possess more or less the properties above mentioned as pertaining to kairin.

Kairin is the name given by the authors to oxychinoline-methyl-hydrate.

Kairin hydrochlorate forms a light grayish-yellow crystalline powder. It is soluble in water, and has a bitter, aromatic taste.

The authors have found that, beginning with doses of from 0.3–0.5 to 1.0 gm. of the above salt, and gradually increasing the dose 0.5 gm. each time, the doses being repeated at intervals of an hour, after the fourth dose the body-temperature may be reduced to 37° C., or even 36.5° C., without any symptoms of local irritation; and they hope that the substance will prove useful in all forms of fever. —*The Druggists' Journal.*

THE ETHER SPRAY AN IMMEDIATE CURE FOR NEURALGIA.—Dr. McColgan extols the value of the ether or rhigolene spray for the instantaneous relief principally of facial neuralgia. He first had occasion to observe its good effects upon his own person, he having suffered greatly from facial neuralgia. Since curing himself, he has had occasion to test its efficacy in about twenty cases. The result was invariably a most gratifying success. In many instances a permanent cure was established. He attempts to explain its action by supposing a complete change to take place in the nutrition of the affected nerve in consequence of the intense cold acting as a revulsive.

A ROVING correspondent, in a letter to the London *Lancet*, says, "In Philadelphia there are practically no tenement-houses, as here land is plentiful, and it is the fashion for every man to own the house in which he lives. Hence, poverty is rare, thrift is everywhere apparent, and the large number of small houses or pretty cottages fills the visitor with astonishment. It would be a grand thing if every father of a family could own his own house, as he does in Philadelphia. This is something for us to aim at accomplishing where possible, and its general adoption would be indeed an approach to the mil-

lennium. It is not possible to obtain this in England, but in Ireland and America the general adoption of this Philadelphia system is greatly to be desired."

THE announcement of the death of Dr. George M. Beard, the well-known medical writer and specialist in diseases of the nervous system, which occurred in New York on the 23d ult., will cause a general feeling of regret at the loss sustained by the profession by his early demise. It was found that he had perished of pneumonia of septicæmic character, resulting from a carious tooth,—in other words, of overwork. Dr. Beard was only forty-three years of age. He was a member of many scientific societies, and was an original thinker, a frequent contributor to medical literature, and generally known as a most industrious worker.

A RECEPTION was given to Dr. John L. Atlee, of Lancaster, Pa., and Dr. Alex. J. Stone, of St. Paul, Minn., the President and Vice-President of the American Medical Association, on the 2d inst., by Dr. John V. Shoemaker, at his residence in this city, which was largely attended. Many representative members of the profession from this city were present, as well as some distinguished guests from other cities.

AFTER this session those colleges which do not require a preliminary examination will be under the ban of the State Board of Health of Illinois, and their graduates will be obliged to undergo an examination before the Board before they will be allowed to practise medicine in that State.

THE *Official Messenger* publishes a decision of the Medical Council of St. Petersburg condemning the homœopathic remedy for diphtheria, which has lately been tried there in the hospitals of the Red Cross Society, as false and dangerous.

THE THIRD CORPUSCLE OF THE BLOOD.—Mrs. Ernest Hart, in the *London Medical Record*, publishes a criticism upon Dr. Norris's work on the physiology of the blood. She claims that the "invisible corpuscle" described by him is really only a red corpuscle decolorized.

TRUTH THROUGH ERROR.—A busy doctor sent in a certificate of death the other day, and accidentally signed his name in the space for "Cause of Death." The registrar says he wishes the profession would be as accurate generally.

ACCORDING to the returns now made up, 3340 students matriculated in Edinburgh University last year, being an increase of 103 on the preceding year. Of these, 1730 were medical students.

INTERNATIONAL MEDICAL CONGRESS.—We have been officially requested to call the attention of our readers to the fact that the

eight session of the International Medical Congress will be held in Copenhagen, Denmark, from the 10th to the 16th of August, 1883, inclusive.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM JANUARY 27, 1883, TO FEBRUARY 3, 1883.

HEIZMAN, CHARLES L., CAPTAIN AND ASSISTANT-SURGEON.—Will be relieved from duty in the Department of the Columbia, and ordered to report to the commanding general, Department of the South, for assignment to duty. Paragraph 10, S. O. 20, A. G. O., January 24, 1883.

KILBOURNE, H. S., CAPTAIN AND ASSISTANT-SURGEON.—Leave of absence for one month, with permission to apply for an extension of two months, is granted. S. O. 218, Department of Dakota, December 21, 1882.

KILBOURNE, HENRY S., CAPTAIN AND ASSISTANT-SURGEON.—The leave of absence granted December 21, 1882, Department of Dakota, is extended two months. Paragraph 3, S. O. 24, A. G. O., January 29, 1883.

MUNDAY, BENJAMIN, FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Assigned to duty at Fort Klamath, Oregon. Paragraph 3, S. O. 195, Department of the Columbia, December 29, 1882.

PAULDING, H. O., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one month, to take effect on or about the 1st of February proximo. Paragraph 1, S. O. 11, Department of the Platte, January 27, 1883.

PRICE, CURTIS E., CAPTAIN AND ASSISTANT-SURGEON.—Detailed as member of Army Retiring Board to convene at Fort Porter, Buffalo, New York, February 2, 1883. Paragraph 1, S. O. 21, A. G. O., January 25, 1883.

SKINNER, JOHN O., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one month. Paragraph 2, S. O. 5, A. G. O., January 6, 1883.

SKINNER, JOHN O., CAPTAIN AND ASSISTANT-SURGEON.—Will report in person, at the expiration of his present leave of absence, to the Surgeon-General, for duty in his office. Paragraph 10, S. O. 20, A. G. O., January 24, 1883.

SPENCER, WILLIAM G., CAPTAIN AND ASSISTANT-SURGEON.—The leave of absence on surgeon's certificate of disability granted September 20, 1882, is extended three months on surgeon's certificate of disability. Paragraph 4, S. O. 16, A. G. O., January 19, 1883.

TAYLOR, MARCUS E., CAPTAIN AND ASSISTANT-SURGEON.—Will report in person, at the expiration of his present leave of absence, to the commanding general, Department of the East, for assignment to duty. Paragraph 10, S. O. 20, A. G. O., January 24, 1883.

WOOD, MARSHALL W., CAPTAIN AND ASSISTANT-SURGEON.—Will be relieved from duty in the Department of the East, at the expiration of his present leave of absence, and will report in person to the commanding general, Department of the Columbia, for assignment to duty. Paragraph 10, S. O. 20, A. G. O., January 24, 1883.

WYETH, M. C., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Is relieved from duty at Fort Snelling, and will proceed to Fort Stevenson, Dakota Territory, and report to the commanding officer of that post for duty. Paragraph 1, S. O. 15, Department of Dakota, January 18, 1883.

WATERS, WILLIAM E., MAJOR AND SURGEON.—Detailed as member of Army Retiring Board to convene at Fort Porter, Buffalo, New York, February 2, 1883. Paragraph 1, S. O. 21, A. G. O., January 25, 1883.

WOOD, MARSHALL W., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one month. Paragraph 3, S. O. 4, Department of the East, January 8, 1883.

WOOD, MARSHALL W., CAPTAIN AND ASSISTANT-SURGEON.—At expiration of present leave of absence, relieved from duty in the Department of the East. Paragraph 1, S. O. 15, Department of the East, January 26, 1883.

JOHNSON, R. W., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Granted leave of absence for one month. Paragraph 2, S. O. 4, Department of Dakota, January 5, 1883.